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DIVISION 11

ADMINISTRATIVE PRACTICES

Organization and Information

309-011-0000
Organizational Description

(1) Purpose. This rule describes the organization of the Mental Health and Developmental Disability Services Division. The Mental Health and Developmental Disability Services Division was previously known as the Mental Health Division.

(2) Statutory Authority. This rule is authorized by ORS 430.041 and carries out the provisions of ORS 183.330(1).

(3) Goal and Organization:

(a) The goal of the Division is to promote mental health and to reduce the negative consequences of mental or emotional disturbances and developmental disabilities;

(b) The Division is under the supervision and control of the Administrator. The Administrator is an Assistant Director of the Department of Human Services and is responsible for the state's mental health and developmental disability programs. The Administrator is ultimately responsible for prevention, treatment, and rehabilitation programs supported by public funds;

(c) The following positions, with the Administrator, comprise the Executive Council of the Division: Deputy Administrator, Assistant Administrator for the Office of Mental Health Services, Assistant Administrator for the Office of Developmental Disability Services, Assistant Administrator for Administrative Services, Superintendent of Dammasch State Hospital, Superintendent of Oregon State Hospital, Superintendent of Fairview Training Center, Superintendent of Eastern Oregon Psychiatric and Training Center, Assistant Administrator of Personnel Services, Communications Manager, and Manager, Office of Client Rights. The Executive Council meets regularly to assist the Administrator in the management of the state's mental health and developmental disability programs. The Administrator has the ultimate responsibility for all decisions;

(d) The Deputy Administrator is responsible for assisting the Administrator in directing, managing, coordinating programs for the Division, and supervising the Computer Services Section;

(e) The Program Offices are responsible for planning, designing, and developing resources for programs throughout the state and ensuring the quality, effectiveness, and efficiency of those programs. Each Program Office is directed by an Assistant Administrator. The Office of Mental Health Services was previously known as the Program Office for Mental or Emotional Disturbances and the Office of Developmental Disability Services was previously known as the Program Office for Mental Retardation and Other Developmental Disabilities;

(f) The Assistant Administrator for Administrative Services is responsible for the following administrative and support functions: Managing the Division's contractual relationship with providers of local mental health and developmental disability services; legal and financial compliance audits and for managing the budgeting and business operations of the Division to expedite the effective delivery of services. The functions performed by the Office of Administrative Services support all Division programs;

(g) The Superintendents of the five state institutions are responsible for the operation, control, and management of those institutions;

(h) The Assistant Administrator of Personnel Services is responsible for directing Division-wide labor relations activities; personnel services; personal services position information control system (PICS); classification and allocation; and affirmative action/equal employment

opportunity (EEO) to assure compliance with federal and state laws, merit system principles, and labor union contracts;

(i) The Communications Manager is responsible for developing and coordinating a statewide communications plan for the Division, producing informational materials; providing communications counseling and assistance to staff. The position serves as spokesperson for the Division and works as a communications liaison to the Department of Human Services;

(j) The Manager, Office of Client Rights is responsible for independent investigations of patient and resident abuse cases, conducting investigations on behalf of the Administrator, and liaison with the various family and consumer advocacy groups representing the Division's clients.

Stat. Auth.: ORS 179, 183.330(1) & 430.045
Stats. Implemented:
Hist.: MHD 6, f. 2-18-72, ef. 3-11-72; MHD 19, f. 5-31-74, ef. 6-25-74; MHD 18-1980, f. & ef. 12-2-80; MHD 19-1983, f. & ef. 9-23-83; MHD 4-1990, f. 4-26-90, cert. ef. 4-30-90

309-011-0010
Obtaining Information

(1) Purpose. This rule prescribes the method whereby the public may obtain information or make submissions or requests of the Division.

(2) Statutory Authority. This rule is authorized by ORS 179.040 and carries out the provisions of ORS 183.330.

(3) Obtaining Information. The public may obtain information or make submissions or requests of the Division by contacting the Communications Manager, Mental Health and Developmental Disability Services Division, 2575 Bittern Street, N.E., Salem, OR 97310.

Stat. Auth.: ORS 179.040 & 183.330
Stats. Implemented:
Hist.: MHD 6, f. 2-18-72, ef. 3-11-72; MHD 20, f. 5-31-74, ef. 6-25-74; MHD 9-1986, f. & ef. 9-26-86; MHD 5-1990, f. 4-26-90, cert. ef. 4-30-90

Mental Health Advisory Board

309-011-0040
Purpose and Statutory Authority

(1) Purpose. These rules describe the organization and responsibilities of the Mental Health Advisory Board.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 430.050.

Stat. Auth.: ORS 430.041 & 430.050
Stats. Implemented:
Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90

309-011-0045
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Department of Human Services, and Administrator for Mental Health and Developmental Disability Services Division.

(2) "Consumer" means a person receiving or eligible to receive services under rules of the Division.

(3) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(4) "Mental Health Advisory Board" means a board appointed by the Administrator and approved by the Governor to study the problems of persons with mental illness or developmental disabilities, assist in planning, and make recommendations to the Administrator for the development of policies and procedures with respect to the state mental health services, and developmental disabilities services programs.

(5) "Disabled Person" means any person who:

(a) Has a physical or mental impairment which substantially limits one or more major life activities;

(b) Has a record of such an impairment; or

(c) Is regarded as having such an impairment.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 4-1995, f. 5-31-95, cert. ef. 6-1-95

309-011-0050
Organization

(1) The Mental Health Advisory Board shall be composed of at least 15 but not more than 20 lay and professionally trained individuals.

(2) The Administrator, with the approval of the Governor, shall appoint the board members.

(3) Board members shall provide a balanced representation of program areas and populations served, and shall reflect the diverse ethnic, age and disability characteristics of consumers of services provided in Division programs.

(4) At least two members of the Board shall be disabled persons, one of whom is a consumer of mental health services and one of whom is a consumer of developmental disability services. Two additional members of the Board shall be consumers or family members of consumers.

(5) Members of the board shall serve for terms of four years expiring on the last day of odd numbered years.

(6) Members are entitled to compensation and expenses as provided in ORS 292.495.

(7) The Administrator may remove any member of the board for misconduct, incapacity or neglect of duty. Any member who is absent from three consecutive meetings of the Board may be removed, at the Administrator's discretion.

(8) The Administrator may make provision for technical and clerical assistance to the Mental Health Advisory Board and for the expense of such assistance.

(9) The board shall meet at least twice each year.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90; MHD 4-1995, f. 5-31-95, cert. ef. 6-1-95

309-011-0055
Responsibilities

(1) The board shall assist the Division in planning and preparation of administrative rules for the assumption of responsibility for psychiatric care in state and community hospitals by community mental health programs, in accordance with ORS 430.630(3)(e).

(2) The board shall study the problems of mental health services, and developmental disabilities services and make recommendations for the development of policies and procedures with respect to these programs.

(3) The board shall review state laws and legislative concepts relative to state mental health services and developmental disabilities services programs.

(4) The board shall review and consider funding of state mental health services, and developmental disabilities services programs and make recommendations.

(5) The board shall advise the Administrator on the relationship of mental health and developmental disability programs to other state, local and private services and make recommendations for collaborative or joint program developments.

(6) The board shall serve as a consulting body to the Administrator.

(7) The board shall encourage public understanding and acceptance of state mental health services, and developmental disabilities services programs.

Stat. Auth.: ORS 243, 430.041 & 430.050
Stats. Implemented:
Hist.: MHD 6-1982, f. & ef. 3-23-82; MHD 3-1990, f. 4-26-90, cert. ef. 4-30-90

Nondiscrimination on Basis of Handicap

309-011-0070
Purpose and Statutory Authority

(1) Purpose. These rules prescribe the procedures to be followed by the Mental Health and Developmental Disability Services Division and its contractors to prevent discrimination on the basis of physical or mental handicap.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 430.041(1) and carries out the provisions of ORS 243.305.

Stat. Auth.: ORS 243 & 430
Stats. Implemented:
Hist.: MHD 4-1987, f. & ef. 6-23-87

309-011-0075
Definitions

As used in these rules:

(1) "Recipient" means any state or its political subdivision, any instrumentality of a state or its political subdivision, any public or

private agency, institution, organization or other entity, or any person to which federal financial assistance is extended directly or through another recipient, including any successor, assignee, or transferee of a recipient, but excluding the ultimate beneficiary of the assistance.

(2) "Facility" means all or any portion of buildings, structures, equipment, roads, walks, parking lots, or other real or personal property.

(3) "Handicapped Person" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(4) "Has a Record of Such an Impairment" means has a history of, or has been misclassified as having a mental or physical impairment that substantially limits one or more major life activities.

(5) "Is Regarded as Having an Impairment" means:

(a) Has a physical or mental impairment that does not substantially limit major life activities but is treated by a recipient as constituting such a limitation;

(b) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(c) Has none of the impairments defined in this section but is treated by a recipient as having such an impairment.

(6) "Major Life Activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, speaking, breathing, learning, and working.

(7) "Physical or Mental Impairment" means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. Alcohol and drug addiction are also considered handicapping conditions.

(8) "Qualified Handicapped Person" means:

(a) With respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question; and

(b) With respect to services and programs provided by the Mental Health and Developmental Disability Services Division or its contractors, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

(9) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

(10) "Section 504" means Section 504 of the Rehabilitation Act of 1973, Public Law 93-112, as amended by the 1974 Act, Public Law 93-516, **29 U.S.C. 794**.

(11) "504 Coordinator" means that individual designated by position description as having the job responsibilities cited in OAR 309-011-0085(1), for the Mental Health and Developmental Disability Services Division.

(12) "Facility 504 Coordinator" means that individual designated by a state mental health institution superintendent to coordinate the responsibilities cited in OAR 309-011-0085(2), for that institution.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 243 & 430
Stats. Implemented:
Hist.: MHD 4-1987, f. & ef. 6-23-87

309-011-0080
Policy

(1) No otherwise qualified handicapped person shall, solely by reason of a handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in any program or activity conducted by the Mental Health and Developmental Disability Services Division and/or its contractors.

(2) The Mental Health and Developmental Disability Services Division and/or its contractors shall make reasonable accommodations to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the Division and/or its contractor can demonstrate that accommodations would impose an undue hardship on the operation of its program.

(3) The Mental Health and Developmental Disability Services Division and/or its contractors shall not use criteria or methods of administration that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of this rule.

(4) In determining the site or location of a new facility, the Mental Health and Developmental Disability Services Division and/or its contractors shall not make selections that exclude handicapped persons from use of the new facility or deny handicapped persons the benefit of the new facility.

(5) The Mental Health and Developmental Disability Services Division and/or its contractors may limit access of nonhandicapped persons to programs which have special features or are specifically designed to afford the handicapped an equal program or service generally available to the nonhandicapped.

Stat. Auth.: ORS 243 & 430
Stats. Implemented:
Hist.: MHD 4-1987, f. & ef. 6-23-87

309-011-0085
Responsibility

(1) Central Mental Health. The 504 Coordinator shall:

(a) Represent the Mental Health and Developmental Disability Services Division in activities or meetings regarding federal regulations relevant to Section 504 of the Rehabilitation Act of 1973;

(b) Provide technical assistance to elements of the Mental Health and Developmental Disability Services Division in interpretation of federal regulations and preparation/implementation of corrective action plans;

(c) Evaluate Central Office activities each biennium to identify potential employment and service barriers to assure compliance with Section 504;

(d) Maintain a central file of all Mental Health and Developmental Disability Services Division compliance reviews and corrective action plans; and

(e) Determine if Mental Health and Developmental Disability Services Division contractors have complied with this rule.

(2) State Mental Health Institutions. Each superintendent of a state institution shall:

(a) Designate a staff member Facility 504 Coordinator for that institution;

(b) Evaluate the state institution's activities each biennium to identify potential employment and service barriers to the handicapped in order to assure compliance with Section 504, of the Federal Rehabilitation Act of 1973;

(c) Prepare and update, each evaluation, a plan for the removal of any employment and service barriers that prevent the accommodation of handicapped clients, staff, and visitors;

(d) File a copy of each state institutional plan with the Mental Health and Developmental Disability Services Division 504 Coordinator; and

(e) Assure plan to comply with Section 504, of the Rehabilitation Act of 1973, is implemented throughout the facility.

Stat. Auth.: ORS 243 & 430
Stats. Implemented:
Hist.: MHD 4-1987, f. & ef. 6-23-87

309-011-0090
Implementation

(1) Employees:

(a) All existing and new employees shall be notified in writing about this policy;

(b) Continuing notification of this policy shall be provided by posting notices on bulletin boards in each Mental Health and Developmental Disability Services Division state institution and the Central Office.

(2) Contractors:

(a) Contractors who are primarily service providers shall be notified in writing they are subject to these regulations;

(b) Future contracts with providers of service shall contain provisions for the assurance of compliance;

(c) Elements of Mental Health and Developmental Disability Services Division issuing contracts to service providers may either:

(A) Obtain a written assurance of compliance from each service provider; or

(B) Include in the purchase document a stipulation that purchase is conditioned on compliance with these regulations.

Stat. Auth.: ORS 243 & 430
Stats. Implemented:
Hist.: MHD 4-1987, f. & ef. 6-23-87

309-011-0095
Grievance Procedure

(1) Any employee of the Mental Health and Developmental Disability Services Division who believes he or she has been discriminated against under provisions of these regulations may use the grievance procedure in effect at the respective state institution or Central Office.

(2) Any other person who believes he or she has been discriminated against under provisions of these regulations may direct a letter stating the details of the alleged grievance to the Mental Health and Developmental Disability Services Division Administrator. A reply shall be prepared within 30 days. Information about this procedure is available from the affirmative action officer at each state institution or Central Office.

(3) Any person using either of the above grievance procedures will retain the right to pursue their claim through other appropriate civil procedures.

(4) Upon a determination by the Mental Health and Developmental Disability Services Division that a contractor has failed to comply with the provisions of this rule, appeal by the contractor may be made in writing to the Administrator or his or her designee. The Administrator shall reply in writing within 30 days.

Stat. Auth.: ORS 243 & 430
Stats. Implemented:
Hist.: MHD 4-1987, f. & ef. 6-23-87

DIVISION 12

ADMINISTRATIVE PRACTICE AND PROCEDURE

[ED. NOTE: Administrative Practice and Procedure Rules, OAR 309-012-0000 & 309-012-0005, were repealed effective 6-1-06. The Department will adhere to the Procedural Rules in OAR 407-001.]

309-012-0025
Procedures for Appeals of Reimbursement Orders

(1) Purpose. This rule prescribes procedures for appeals of Reimbursement Orders issued by the Mental Health and Developmental Disability Services Division.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 179.770(1), 183.341(2), and 430.041(1) and carries out the provisions of ORS 179.610 to 179.770.

(3) Definitions. As used in this rule:

(a) "Administrator" means the Administrator of the Mental Health Division;

(b) "Authorized Representative" means those parties named in ORS 305.240, or those parties who are determined to have the authority to represent the person;

(c) "Division" means the Mental Health Division of the Department of Human Services;

(d) "Hearing" means the hearing authorized by ORS 179.640(3) for the purpose of review of Reimbursement Orders and modified Reimbursement Orders issued pursuant to ORS 179.640(1) and (2);

(e) "Hearings Officer" means any person designated by the Administrator to hold hearings on matters coming before the Division. Staff of the Reimbursement Section of the Division may not be designated as hearings officers;

(f) "Informal Conference" means a proceeding held before the appeal hearing to allow the person to obtain a review of the action or proposed action without the necessity of a formal hearing;

(g) "Person" means:

(A) A patient who is receiving or has received treatment or care at a state institution for the mentally ill;

(B) A current or former resident at a state institution for the mentally retarded;

(C) The estate of the person;

(D) Any other individual or entity having a financial interest in contesting a Reimbursement Order.

(h) "Reimbursement Order" means the order issued to determine the person's ability to pay pursuant to ORS 179.640(1) and (2);

(i) "Service" means deposit of a Reimbursement Order by U.S. mail, state mail, or deposit with a state institution for hand delivery;

(j) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(4) Authorization for Hearing: A hearing before the Administrator or a Hearings Officer shall be granted to a person who appeals to the Administrator in the following instances:

(a) A person may appeal the Division's determination or redetermination of the person's ability to pay the state's charges for institutional care and maintenance. The appeal must be submitted within 60 days of the service of the Reimbursement Order;

(b) The Division, on or about the time of the person's discharge, shall determine whether or not any of the funds previously paid by the person or on his or her behalf to the State of Oregon to cover his or her cost of care should be reimbursed to the person to satisfy his or her financial needs upon release, or whether any of the previous Reimbursement Orders for the current hospitalization should be modified. This redetermination may be appealed within 60 days of service.

(5) Request for Hearing:

(a) No particular format for a request for a hearing is required, but, to be considered, each request must be in writing and must specify:

(A) The name and address of the person requesting the hearing;

(B) The action being appealed, including:

(i) The year or years involved;

(ii) A reference to any Division correspondence on the subject known to the person;

(iii) Why the action being appealed is claimed to be incorrect;

(iv) The specific relief requested.

(b) The request for a hearing must be signed by the person or his or her authorized representative;

(c) All requests for hearings shall be filed by mailing or delivering the appeal to the Reimbursement Section, Mental Health and Developmental Disability Services Division, P.O. Box 14250, Salem, OR 97310;

(d) If the request for a hearing is considered insufficient in content by the Division, the Division may require the request to be reasonably supplemented with additional information before any further action is taken on the appeal;

(e) Prior to the time of an appeal hearing, if there is no objection by the person, the Hearings Officer may refer the matter in controversy for an informal conference for settlement or simplification of issues.

(6) Authorization for Informal Conference:

(a) A person who has requested an appeal hearing pursuant to section (5) of this rule may request that he or she have an informal conference with a representative from the Reimbursement Section before the formal appeal hearing. Any request for an informal conference may be granted at the discretion of the Division;

(b) Such conferences are informal. A person may represent himself or herself or may choose someone to act as his or her representative. The purpose of the conference is to allow a person to obtain a review of the action or proposed action (without the necessity of a formal appeal hearing), if he or she believes that an action made or proposed by the Division is incorrect;

(c) Payment of the proposed charge for institutional care and maintenance will not jeopardize a conference request or decision.

(7) Request for Informal Conference:

(a) A conference request may be filed either with a hearing request required in section (5) of this rule or subsequent to the hearing request but at least 14 days before the date of a scheduled hearing;

(b) The conference request shall be in writing and must specify:

(A) The name and address of the person requesting the conference;

(B) The reason for the request, including:

(i) In what respect the action or proposed action of the Division is erroneous;

(ii) Reference to any prior Division correspondence on the subject.

(c) If a hearing has been requested, the material submitted as part of the request for a hearing may be used at the informal conference;

(d) The conference request should be addressed to the Reimbursement Section, Mental Health and Developmental Disability Services Division, P.O. Box 14250, Salem, OR 97310.

(8) Conduct of Informal Conference. A conference shall be held at a place designated by the Division. To the extent practical, the conference will be held at a location convenient to the person. The conference shall begin with a statement from the Division. The person requesting the conference shall then state his or her position, the facts as he or she knows them, and his or her questions of persons present to clarify the issues.

(9) Disposition of Informal Conference:

(a) After the conference, the Reimbursement Section will issue a proposed order disposing of the appeal for approval by the Administrator. The written order, approved by the Administrator, will be sent to the person within 14 days of the conference, unless during the conference the Division action is conceded by the person to be correct;

(b) The person's request for a hearing will be stayed pending the outcome of the conference, at which time the request for a hearing will either be withdrawn by the person should he or she no longer desire to proceed, or the hearing will be rescheduled;

(c) When a decision favors the person, the person will receive a refund;

(d) The person may request within 30 days that the decision made at an informal conference be reconsidered by the Administrator. The person should set forth the specific ground or grounds for requesting the reconsideration.

(10) Subpoenas and Depositions:

(a) The Division shall issue subpoenas to any party to a hearing upon request. Witnesses appearing pursuant to subpena, other than parties or employees of the Division, shall receive fees and mileage as prescribed by law for witnesses in a civil action;

(b) Depositions may be taken on petition of any party to a hearing.

(11) Conduct of Appeal Hearing:

(a) To the extent practical, the Division, in designating the location of the hearing, shall designate a place convenient for the person;

(b) The hearing shall be conducted by and shall be under the control of the Hearings Officer;

(c) The Hearings Officer shall administer an oath or affirmation of the witnesses;

(d) A verbatim record shall be made of all testimony and rulings. Parties who wish a transcription of the proceedings should make arrangements with the Division. If the Division determines the record is no longer needed, the Division may destroy the record after 180 days following the issuance of a final order, unless within the 180-day period arrangements are made by the person for further retention by the Division;

(e) The hearing shall begin with a statement of the facts and issues involved. The statement shall be given by a person requested to do so by the Hearings Officer;

(f) The Hearings Officer may set reasonable time limits for oral presentation and may exclude or limit testimony that is cumulative, repetitious or immaterial.

(12) Evidentiary Rules:

(a) All evidence of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs shall be admissible;

(b) The Hearings Officer shall receive all physical and documentary evidence presented by parties where practicable. All offered evidence is subject to the Hearings Officer's power to exclude or limit cumulative, repetitious or immaterial matter;

(c) Evidence objected to may be received by the Hearings Officer, and rulings on its admissibility or exclusion may be made at the time a final order is issued;

(d) At the time of the hearing, the person will be notified that any exhibit introduced as evidence at the hearing will be destroyed after 180 days following the issuance of a final order, unless within the 180-day period, written request is made by the person presenting the exhibit for the return of the exhibit;

(e) The burden of presenting evidence to support a fact or position in a hearing rests on the proponent of the fact or position.

(13) Disposition of Appeal:

(a) After a hearing has been held, the Hearings Officer shall issue a proposed order, including findings of fact and conclusions of law. If the proposed order is adverse to the person, it shall be served upon the person and an opportunity afforded to the person to file exceptions and present written argument to the Administrator before a final order is issued. A person has a ten-day period in which to file exceptions and/or written argument to a proposed order;

(b) Final orders on a hearing shall be in writing and shall include:

(A) Rulings on admissibility of offered evidence;

(B) Findings of fact — Those matters which are either agreed as fact or which, when disputed, are determined by the Administrator, on substantial evidence, to be a fact over contentions to the contrary;

(C) Conclusions of law — Applications of the controlling law to the facts found and the legal results arising therefrom;

(D) The action taken by the Division as a result of the findings of fact and conclusions of law; and

(E) Notice of the person's right to judicial review of the order.

(c) Parties to a hearing and their attorneys shall be mailed a copy of the final order and accompanying findings and conclusions.

(14) Administrative Review of Final Order:

(a) A person may file a petition for administrative review of the final order with the Division within 30 days after the order is served. The petition shall set forth the specific ground or grounds for requesting the review. The petition may be supported by a written argument. Examples of sufficient grounds are:

(A) The Division action is not supported by the written findings, or the written findings are inaccurate; or

(B) Pertinent information was available at the time of the original hearing which, through no fault of the party, was not considered; or

(C) The action of the Division is inconsistent with its rules or policies or is contrary to law; and

(D) The matters raised on appeal may have an effect on the original decision.

(b) The Division may grant a rehearing petition if sufficient reason therefor is made to appear. The rehearing may be limited by the Division to specific matters. If a rehearing is held, an amended order shall be entered;

(c) If the Division denies the appeal, it shall inform the person in writing of the denial;

(d) If the administrative review has been requested, the Division order is not final until the administrative review is granted or denied.

(15) Time Extensions. Where any provision of this rule specifies a particular time period in which a person must act, for good cause shown, the Hearings Officer may, in his or her discretion, allow a reasonable extension of time if so doing is not inconsistent with ORS 179.640 to 179.650.

(16) Appeal. An appeal from the final order of the Division may be taken as provided by law. *Caution:* Either ORS 179.650 or 183.482 may be applicable. See League of Women Voters v. Lane County Boundary Commission, 32 Or. App. 53, 573P.2d 1255, rev. denied, 283 Or. 503 (1978).

Stat. Auth.: ORS 179, 183 & 430
Stats. Implemented:
Hist.: MHD 6-1979(Temp), f. & ef. 9-20-79, MHD 1-1980, f. & ef. 1-14-80

Determination of Ability to Pay Cost of Care in State Institutions

309-012-0030
Purpose and Statutory Authority

(1) Purpose. Individuals admitted to Mental Health and Developmental Disability Services Division institutions are liable for the full cost of their care, but are required to pay only what they are able to pay. This rule establishes guidelines for determining a person's ability to pay for the cost of care in a state institution.

(2) Statutory Authority. This rule is made necessary by ORS 179.640(1), and authorized by ORS 179.770(1), 183.341(2) and 430.041(1), and carries out the provisions of ORS 179.610 to 179.770.

Stat. Auth.: ORS 179, 183 & 430
Stats. Implemented:
Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0031
Definitions

As used in these rules:

(1) "Ability to Pay" means the ability of a person in a state institution to pay past, current, or ongoing cost of care, as determined by the Division in accordance with these rules.

(2) "Assets" means, excluding income, the total value of an individual's equity in real and personal property of whatever kind or nature. Assets include, but are not limited to the individual's stocks, bonds, cash, accounts receivable, moneys due, or any other interests, whether they are self-managed, or held by the individual's authorized representative, or by any other individual or entity on behalf of the individual. "Assets" held in trust are subject to laws generally applicable to trusts.

(3) "Authorized Representative" means an individual or entity appointed under authority of ORS 126.103 or 126.157, as guardian or conservator of a person, who has the ability to control the person's finances, and any other individual or entity holding funds or receiving benefits or income on behalf of any person.

(4) "Benefits from Health Insurance" means payments from insurance programs with the limited purpose of paying for the cost of care provided to an individual by a hospital or other health care provider. Benefits of this type include, but are not limited to payments from:

(a) Private and group health insurance policies;

(b) The Medicare and Medicaid programs;

(c) Any other policies or programs with the purpose of paying for the costs of inpatient and/or outpatient care.

(5) "Charges" means the amount the Division has determined that the person is required to pay toward the cost of care based on his or her ability to pay.

(6) "Cost of Care" means the person's full liability for care as determined by the Division using the rates established in accordance with ORS 179.701.

(7) "Dependents" means individuals whom a person has a legal duty to support. "Dependents" may include non-emancipated children and spouse of a person, as well as any other individual for whom a person would be allowed a personal exemption under federal or Oregon personal income tax laws.

(8) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(9) "Fair Market Value" means the cash price a capable and diligent individual could obtain in a reasonable amount of time for an asset after negotiating with those accustomed to buying such property.

(10) "Funds for Personal Support Following Release" means the cash that a person will need following his/her release from a state institution to live in the community in a reasonable manner for a period of time, not normally to exceed six months.

(11) "Income" means all funds received by an individual, or for an individual by his or her authorized representative, from any source, whether earned or unearned, after making applicable deductions for state and federal taxes. "Income" includes benefits from both income protection insurance which replaces the person's earned income when he or she is unable to work, and governmental retirement or disability insurance, such as Social Security, Veterans, and Railroad Retirement benefits.

(12) "Legal Obligations" means any financial duty imposed by law. "Legal obligations" include, but are not limited to, loan or mortgage contracts for which an individual is responsible, as well as liabilities arising out of other contracts or legal duties to pay money. "Legal obligations" include administratively or judicially ordered child and/or spousal support.

(13) "Moral Obligations" means any payments that an individual feels a moral duty to pay, but for which the individual does not have a legal duty to pay.

(14) "Person" means:

(a) A current or former patient at a state institution for the mentally and emotionally disturbed;

(b) A current or former resident at a state institution for the developmentally disabled.

(15) "Person's Representative" means:

(a) Any individual who is the person's authorized representative as defined in section (3) of this rule; and/or

(b) Any other individual who has the person's written authority to represent the person.

(16) "Personal Expense Allowance" means the cash allowed for the reasonable miscellaneous expenses the person has while he or she is in the state institution, including but not limited to expenses for personal grooming and hygiene items; books, newspapers, or other publications; snacks or refreshments not provided by the state institution; and minor entertainment or excursions.

(17) "Primary Personal Automobile" means the automobile, if the person has more than one, which the person would choose to keep if required to sell all but one. If the person has only one, it is the primary personal automobile.

(18) "Primary Personal Residence" means the home the person owns, or is purchasing, and in which the person lived prior to entering the state institution, and/or in which the person will live after leaving the state institution.

(19) "Special Authorized Expense Allowance" means the cash needed for the reasonable personal expenses of the person which cannot be met by the personal expense allowance, and which the Division determines are necessary.

(20) "State Institution" means Dammasch State Hospital in Wilsonville; Eastern Oregon Psychiatric Center in Pendleton; Eastern Oregon Training Center in Pendleton; Fairview Training Center in Salem; and Oregon State Hospital in Salem.

(21) "Support for Dependents" means the cash necessary to meet the reasonable needs of the dependents, less the amounts the dependents receive from any other sources. Support for dependents excludes administratively or judicially ordered child and/or spousal support.

Stat. Auth.: ORS 179, 183 & 430
Stats. Implemented:
Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0032
Requirements for Obtaining Financial Information

(1) Information Obtained from the Person and/or the Person's Representative. The Division shall require the person and/or the person's representative to submit financial information on forms provided by the Division. Financial information required by the Division shall include, but shall not be limited to the following:

(a) A description of the person's assets, and their values;

(b) A description of the person's liabilities, the dates they were incurred, the total amounts owing, and a schedule of actual or planned payment dates and amounts;

(c) The sources and amounts of the person's income;

(d) The sources of available benefits from health insurance;

(e) A description and the amounts of the person's expenses;

(f) The names and ages of any dependents, and the sources and amounts of income and assets, other than those of the person, which are available for their support; and

(g) The income, assets, and liabilities of the person's spouse or other individual who shares the person's expenses;

(h) Other information the person and/or the person's representative considers important to the determination of the person's ability to pay.

(2) Information Obtained from Other Sources. In addition, the Division may obtain financial information regarding the person from other sources the Division considers to be reliable. These sources may include, but are not limited to, the Social Security and Veterans Administrations, Oregon Department of Revenue, and other Department of Human Services agencies.

Stat. Auth.: ORS 179, 183 & 430
Stats. Implemented:
Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0033
Procedures for Determining Ability-to-Pay for Cost of Care

(1) Ability-to-Pay Orders — Based on the financial information received or obtained, the Division will determine the person's ability to pay. If the person, and/or the person's authorized representative fails to provide sufficient information to show the person cannot pay the full cost of care, the Division may determine the person has the ability to pay the full cost of care. The determination of the person's ability to pay shall be set forth in an Ability-to-Pay Order. The four types of Ability-to-Pay orders are Determination of Charges, Modification to Charges, Return of Funds for Personal Support Following Release, and Waiver of Charges. Each Order shall be given one of these titles to identify the type of determination it sets forth, and it shall be based on the factors and criteria described in the following sections.

(2) Limit on Charges — The amount determined by the Division to be the person's charges shall not exceed the full cost of care for the

dates of service covered by the Ability-to-Pay Order, less payments and/or credits from any other sources the Division has received, or reasonably anticipates receiving.

(3) Determination of Charges — An Ability-to-Pay Order which sets forth a determination of the person's charges for the care received which is made either while the person is in the state institution, or after the person's release from the state institution. A Determination of Charges may be issued any time during the person's stay in the state institution. A Determination of Charges will be issued after the person's release if none was issued during the person's stay, or if the person's financial circumstances change to enable the person to pay cost of care which exceeds amounts charged by previous Ability-to-Pay Orders. When issuing a Determination of Charges, the Division will consider the following factors:

(a) Factors relating to the person's eligibility for and coverage by benefits from health insurance;

(b) Factors relating to the person's assets:

(A) Except as otherwise provided in this section, charges will be assessed using the person's equity in all assets whether the asset is controlled by the person, or by the person's authorized representative. The Division will determine the person's equity in each asset by deducting from the fair market value of the asset any bona fide encumbrance against the asset;

(B) Charges will be assessed using the person's equity in a primary personal residence only if:

(i) Information is provided by the treatment staff at the state institution stating the person cannot reasonably be expected to return to the residence to live at any time following discharge from the institution; and

(ii) None of the following individuals is residing in the residence:

(I) The person's spouse;

(II) The person's child or children under age 21, or blind or disabled;

(III) The person's sibling or siblings who own an interest in the residence, and who lived in the residence for at least one year immediately prior to the person's admission to the state institution;

(IV) The person's parents or emancipated children who are unable to work to maintain themselves as declared in ORS 109.010.

(C) No charge will be assessed using the person's equity in a primary personal automobile;

(D) The value of an asset which has great sentimental value to the person (such as a family heirloom or gift from a loved one) may be disregarded if selling the asset would cause the person great emotional distress. The Division shall confer with the person's treatment staff to decide whether or not to make this disregard;

(E) When assets are used as the basis for ongoing charges, the Division will estimate the length of time the assets are expected to last. During the final 60 days of that time period, the Division will review the person's financial circumstances in preparation for modifying the person's charges.

(c) Factors relating to the person's income:

(A) Charges will be assessed using the total amount of all income received either by the person, or for the person by the person's authorized representative;

(B) Income received at intervals other than monthly may be prorated for use in a calculation of a monthly charge to the person.

(d) Factors relating to the person's legal and moral obligations:

(A) For legal obligations other than administratively or judicially ordered child and/or spousal support, the person must have demonstrated an intent to pay the obligation, either by showing a history or regular payments toward the full amount owing, or by providing a plan showing dates and amounts of payments to be made in the future;

(B) The Division shall seek the advice of treatment staff as to whether or not, in the interest of the person's rehabilitation, welfare, and/or treatment, the person's need to satisfy declared moral obligations should be given priority over the person's obligation to pay the cost of care;

(C) Any deduction allowed by the Division for legal or moral obligations must be used to satisfy the current obligation. It may not be accumulated by, or on behalf of the person, or used for purposes other than that for which it was approved.

(e) Factors relating to the person's obligation to provide financial support for dependents:

(A) Before approving a deduction for financial support for a dependent, the Division shall determine how much money is required to reasonably support the dependent. From that amount, the Division shall subtract any funds available from sources other than the person, such as the dependent's own income and assets, or any form of governmental aid such as public assistance payable to, or on behalf of the dependent;

(B) Any deduction allowed by the Division for the financial support of dependents must be used to provide current support. It may not be accumulated by, or on behalf of the person, and it may not be used for other purposes.

(f) Factors relating to the person's personal and special authorized expenses while in the state institution:

(A) The personal expense allowance while the person is in the state institution shall be established by the Division to reflect the Supplemental Security Income Program's payment limit for institutionalized individuals (The allowance was $30 per month as of July 1, 1988.);

(B) Special authorized expense allowances while the person is in the state institution shall be approved based on the following criteria:

(i) The state institution treatment staff's advice that satisfying the need will not interfere in any way with the successful treatment or general welfare of the person, and it may enhance the person's ability to meet the goals of the treatment plan; and

(ii) There are no other resources available to meet the need.

(g) Factors related to the person's need for funds for personal support following release from the state institution when the Division is issuing any Ability-to-Pay Order after release or when release is scheduled within 30 days:

(A) As necessary, funds for personal support following release will be allowed to pay for the following items:

(i) Rental costs including the monthly rent payment, as well as one time deposits or fees, or mortgage payments related to the purchase of a residence;

(ii) Food for the person and dependents;

(iii) Utilities such as heating fuel, water, electricity, garbage service, basic telephone service, and basic television cable service;

(iv) Transportation and related insurance coverage;

(v) Routine household maintenance and insurance coverage;

(vi) Health and dental care and related insurance coverage for the person and dependents;

(vii) Clothing and entertainment for the person and dependents; and

(viii) Other personal expenses which the person shows to be reasonable and necessary, including payments toward moral obligations and legal obligations (other than mortgage contracts), as described in subsection (d) of this section.

(B) The funds allowed for personal support following release shall be based on what a reasonable and prudent individual would spend for the items given the resources available to the individual;

(C) The amount approved for support of the dependents shall take into consideration all other resources available to meet the dependent's needs.

(h) Factors relating to the time period during which the Division may assess charges, and the time period during which the person is required to pay assessed charges:

(A) Ability-to-Pay Orders issued after release which establish an ongoing monthly charge based on the person's ability to pay after release shall not add new charges beyond the 36th month following the month in which the person was released from the state institution;

(B) The person is required to pay beyond the 36 month period, any assessed charges not paid prior to release or during the 36 month period after release.

(4) Modification to Charges — An Ability-to-Pay Order which sets forth a modification to the person's charges established by a prior Ability-to-Pay Order. A Modification to Charges will be made to reflect either a change in the person's financial circumstances which affects the person's ability-to-pay ongoing monthly charges, or the Division's receipt of benefits from health insurance that were not recognized in a prior Ability-to-Pay Order, which cause established charges to exceed the maximum cost of care chargeable to the person in accordance with section (2) of this rule. When issuing a Modification to Charges, the Division will consider the same factors used for a Determination of Charges as described in section (3) of this rule.

(5) Return of Funds for Personal Support Following Release — An Ability-to-Pay Order which sets forth a determination by the Division regarding the return of funds paid toward the person's charges to provide the person with adequate funds for personal support following his or her release from the state institution. When issuing a Return of Funds for Personal Support Following Release, the Division will use the following criteria:

(a) A Return of Funds for Personal Support Following Release is subject to the following conditions:

(A) The person or the person's representative has made payments toward the cost of care provided by the state institution.

NOTE: Returned funds for personal support following release cannot exceed the total amount paid from the person's own income and assets. Benefits from health insurance are not included in the amounts paid.

If charges are due, but the person or the person's representative has made no payment, funds for personal support following release will be considered under the provisions for Waiver of Charges;

(B) The person will be discharged from the state institution within the next 30 days, or he/she was discharged from the state institution within the last 60 days;

(C) The person has financial obligations following release from the state institution as described in subsection (3)(g) of this rule which cannot be immediately satisfied with other available resources.

(b) Funds for personal support following release will be provided for a limited amount of time, not normally to exceed six months, during which time the person will be expected to become otherwise supported through employment, public assistance, or other available programs;

(c) Funds for personal support following release for a period of time exceeding six months will be considered only if the Division receives information which shows the person's circumstances require such consideration.

(6) Waiver of Charges — An Ability-to-Pay Order which sets forth a determination by the Division regarding waiver of collection of part or all of the person's unpaid charges based upon the best interest of the person or the Division:

(a) A waiver of charges should be granted when the Division, after considering information regarding extraordinary circumstances pertaining either to the person's financial situation, or the person's physical, psychological, or sociological well-being, determines:

(A) Charges assessed by prior Ability-to-Pay Orders are unpaid, and a subsequent change in the person's circumstances shows that collection of all or part of the unpaid charges would be detrimental to the best interests of the person or of the Division;

(B) Charges assessed by prior Ability-to-Pay Orders are unpaid, and the Division either receives a written statement from the person's treating physician, or accepts, on a case-by-case basis, a non-physician mental health professional's written statement, which indicates the person's physical, psychological, and/or sociological condition is interfering with the person's ability to satisfy the outstanding obligation, and further efforts by the Division to collect the unpaid charges would be harmful to the person; or

(C) Charges have not been assessed by a prior Ability-to-Pay Order extraordinary circumstances as described in paragraph (A) and/or (B) of this subsection are present, and based on those circumstances the charges should not be assessed.

(b) In accordance with ORS 179.640(4), charges may be assessed or reassessed at a later time by a new Determination of Charges Ability-to-Pay Order if the basis for waiver under this section ceases to exist.

Stat. Auth.: ORS 179, 183 & 430
Stats. Implemented:
Hist.: MHD 5-1980(Temp), f. & ef. 4-18-80; MHD 14-1980, f. & ef. 6-24-80; MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0034
Delivery of Ability-to-Pay Orders and Factors Relating to Appeals

(1) Delivery to the Person — The original Ability-to-Pay Order shall be delivered to the person, unless the person has an authorized representative.

(2) Delivery to the Authorized Representative — If the person has an authorized representative, the original Ability-to-Pay Order shall be delivered to the authorized representative, and a copy shall be delivered to the person. Any Ability-to-Pay Order delivered to an authorized representative shall include an explanation of the Division's right to demand payment of the charges assessed by the Order, and the consequences to the authorized representative of failing to comply, as provided by ORS 179.653(3).

(3) Appeal Rights — The Ability-to-Pay Order shall include an explanation of the person's right to appeal the determination set forth by the Order.

(4) Successor Authorized Representative — If the person's authorized representative does not pay or appeal the charges assessed by an Ability-to-Pay Order, and he or she is subsequently replaced by a new authorized representative, the successor authorized representative shall be provided with the opportunity to either pay the assessed charges, or to appeal the determination set forth by the Order. The Division will take the following actions when notified there is a successor authorized representative:

(a) Deliver copies of all Ability-to-Pay Orders not fully paid to the successor authorized representative with a letter which describes the delivery of the Order(s) to the previous authorized representative(s), and any actions taken by the previous representative(s) with regard to the Order(s);

(b) Include with the Order copies, an explanation of the successor authorized representative's right to appeal the determination(s) set forth by the Ability-to-Pay Order(s).

(5) Resolving Appeals — If the person or the person's authorized representative appeals a determination set forth by an Ability-to-Pay Order, the Division will attempt to resolve the appeal by issuing a new Ability-to-Pay Order which takes into consideration the information on which the appeal is based. If the appeal cannot be resolved by issuing a new Order, it will be addressed through the contested case appeal process.

Stat. Auth.: ORS 179, 183 & 430
Stats. Implemented:
Hist.: MHD 9-1991, f. 12-13-91, cert. ef. 12-16-91

309-012-0035
Enforcement of Recoupment Liens

(1) Purpose. This rule establishes procedures for implementing recoupment liens used in carrying out Reimbursement Orders issued by the Mental Health and Developmental Disability Services Division.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 179.770(1) and 430.041(1) and carries out the provisions of ORS 179.653 and 179.655.

(3) Definitions. As used in this rule:

(a) "Cost of Care" means the cost determined by the Mental Health and Developmental Disability Services Division in accordance with ORS 179.701;

(b) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services;

(c) "Person" means:

(A) A patient who is receiving or has received treatment or care at a state institution for the mentally ill;

(B) A current or former resident at a state institution for the mentally retarded.

(d) "Person's Representative" means a conservator, guardian of the person, or estate of the person in a state institution, or an individual who has been appointed by a court in this or another state or by Federal Court to serve as the legal representative of a person in a state institution, and also includes an individual whom a person in a state institution has designated to receive the notice of information involved in the particular transaction;

(e) "Recoupment Lien" means a charge or security or encumbrance upon real or personal property that can be used to satisfy the amount due for the person's cost of care;

(f) "Reimbursement Order" means the order issued to determine the person's ability to pay pursuant to ORS 179.640(1) and (2);

(g) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton;

(h) "Warrant" means the document issued by the Mental Health and Developmental Disability Services Division directed to the sheriff of any county of the state commanding the sheriff to levy upon and sell the real and personal property which is subject to satisfaction of the recoupment lien.

(4) Enforcement of Lien by Issuance of Warrant. The Division shall enforce its recoupment lien created by ORS 179.653 by issuance

of a warrant in the manner stated in ORS 179.655. Any warrant issued by the Division pursuant to ORS 179.655 shall clearly provide that the sheriff or other person executing the warrant shall not levy upon and sell any real or personal property that would be exempt under Oregon law from execution pursuant to a judgment. However, the Division shall not issue a warrant pursuant to ORS 179.655 where:

(a) The amount due to the Division for the cost of care of a person in a state institution is not at least 30 days overdue;

(b) Provision has been made to secure the payment by bond or deposit or otherwise in conformance with section (5) of this rule;

(c) The person has exercised the right to appeal the Reimbursement Order pursuant to OAR 309-012-0025(6) and that appeal is still pending;

(d) Sixty-one days have not passed since the issuance of the Reimbursement Order;

(e) The person or the person's representative has not been given at least ten days' prior written notice that the Division intends to issue such a warrant.

(5) Methods of Securing Satisfaction of Reimbursement Order:

(a) The issuance of a warrant to the sheriff to enforce collection of delinquent money due the Division for the cost of care for a person in a state institution will be stayed either by paying the amount due and accrued interest after it becomes due or by securing payment of that amount by bond or deposit or otherwise;

(b) The bond given by the person must be for an amount not less than the amount due, plus interest for a reasonable period determined by the Division:

(A) The bond must be executed by:

(i) A surety company which is registered with, and under the supervision of, the Insurance Commissioner of the State of Oregon; or

(ii) By two or more individual sureties, each of whom shall be a resident and homeowner or holder of an interest in land within the state and each of whom shall be worth sums specified in the under-taking, exclusive of property exempt from execution and over and above all valid debts and liability.

(B) The Division may allow more than two sureties to justify several amounts less than that expressed in the undertaking, if the whole justification is equivalent to that of two sufficient undertakings.

(c) Any one of the following items, or combination of items acceptable to the Division, equal to the amount due, plus accrued interest thereon, may be deposited with the Division:

(A) A deposit of money;

(B) A certified check or checks on any state or national bank within the State of Oregon payable to the Mental Health Division;

(C) Satisfactory bonds negotiable by delivery, or obligations by the U.S. Government negotiable by delivery; or

(D) Any other security satisfactory to the Division.

(d) The Division may require additional security whenever, in its opinion, the value of the security pledged is no longer sufficient to adequately secure the payment of the amount due, plus accrued interest thereon.

(6) Release of Tax Lien and Clouds on Title. Any request made to the Division for the release of a warrant, where such warrant is not in fact a lien on title to the real property in question but merely a cloud on the title to such real estate, shall be accompanied by a statement. This statement shall show the facts affecting the title to the real property in question that render the Division's warrant a cloud on the title to such real property and the reasons the warrant does not actually constitute a lien thereon:

(a) This type of request for release of a warrant should be accompanied by a current title report;

(b) The Division may require other documentary proof showing the present condition of the title to the property in question.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 8-1980(Temp), f. & ef. 4-18-80; MHD 15-1980, f. & ef. 6-24-80

Charges for Reproduction of Medical Records

309-012-0070
Policy

(1) Requests for copies of medical records must be made in writing with proper consent and must be specific to assure that only the essential portions of the medical record are copied and released.

(2) A patient or resident shall not be denied access to the medical record because of inability to pay. The patient may review his or her record in the Medical Record Department at no charge.

(3) A copy of the most recent release summary shall be furnished free of charge to authorized persons or agencies providing follow-up care.

(4) A copy of required portions of medical records may be provided without charge to the following agencies and individuals. When a substantial part or all of a medical record is requested, the Division may charge for copies in accordance with OAR chapter 407, division 003:

(a) Community mental health programs;

(b) Courts;

(c) Hospitals;

(d) Individuals or agencies providing follow-up care for the patient;

(e) Insurance carriers paying for patient's or resident's care; and

(f) Physicians.

(5) All other requests for public records shall be charged in accordance with OAR chapter 407, division 003.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.050
Hist.: MHD 2-1983(Temp), f. & ef. 2-18-83; MHD 10-1983, f. & ef. 6-8-83; MHS 4-2007, f. & cert. ef. 5-25-07

Amount of Earned Income in Calculation of Ability-to-Pay

309-012-0100
Purpose and Statutory Authority

(1) Purpose. These rules establish the amount of earned income Mental Health and Developmental Disability Services Division excludes when calculating ability-to-pay for cost of care at a mental health institution. The purpose of this earned income exclusion is to reduce the disincentive to work for patients and residents.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 179.770(1).

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0105
Definitions

As used in these rules:

(1) "Earned Income" means money received by a patient or resident in a mental health institution in return for services rendered, while receiving care or treatment at the institution.

(2) "Mental Health Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0110
Earned Income in Calculation of Ability-to-Pay

The Mental Health and Developmental Disability Services Division includes earned income as income in the calculation of ability-to-pay, as described in OAR 309-012-0030.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 11-1985, f. & ef. 6-19-85

309-012-0115
Earned Income Exclusion

The Mental Health and Developmental Disability Services Division allows a patient or resident to retain a portion of any income earned while in a mental health institution. The amount of earned income to be excluded in the calculation of ability-to-pay is determined by subtracting $65 from earned income. An additional $25 will be subtracted from the total income (both earned and unearned) as an allowance for personal need.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 11-1985, f. & ef. 6-19-85

Certificates of Approval for Mental Health Services

309-012-0130
Purpose and Statutory Authority

(1) Purpose. These rules establish procedures for approval of the following kinds of organizations:

(a) Any mental health service provider which is, or seeks to be, contractually affiliated with the Division or community mental health authority for the purpose of providing services described in ORS 430.630(3);

(b) Performing providers under OAR 309-016-0070;

(c) Organizations seeking Division approval of insurance reimbursement as provided in ORS 743.556(3); and

(d) Holding facilities.

(2) These rules do not establish procedures for residential licensure under ORS 443.410 and 443.725.

(3) Statutory Authority. These rules are authorized by ORS 179.040, 179.505, 426.175, 430.010, 430.640 and 743.556.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0140
Definitions

As used in these rules:

(1) "Applicant" is any entity potentially eligible to be approved as a provider under these rules and who has requested, in writing, a Certificate of Approval.

(2) "Certificate of Approval" is the document awarded under these rules signifying that a specific, named organization is judged by the Division to operate in compliance with applicable rules. A "Certificate of Approval" for mental health services is valid only when signed by the Assistant Administrator of the Office of Mental Health Services and, in the case of a subcontract provider of a CMHP, the CMHP director.

(3) "Community Mental Health Program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an agreement or contract with the Mental Health and Developmental Disability Services Division.

(4) "Direct Contract" or "Contract" is the document describing and limiting the relationship and respective obligations between an organization other than a county and the Division for the purposes of operating the mental health program area within a county's boundaries, or operating a statewide, regional, or specialized mental health services.

(5) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(6) "Holding Facility" means hospitals or other facilities, including Division contracted acute care facilities, providing care, custody, and treatment of allegedly mentally ill persons under the emergency provisions of ORS 426.070, 426.175 and 426.215.

(7) "Intergovernmental Agreement" or "Agreement" is the document describing and limiting the contractual relationship and respective obligations between a county or other government organization and the Division for the purpose of operating mental health services.

(8) "Letter of Approval" is the document awarded to service providers under OAR 309-012-0010 which states that the provider is in compliance with applicable administrative rules of the Division. Letters of Approval issued for mental health services are obsolete upon their expiration date, or upon the effective date of this rule, whichever is later. OAR 309-012-0010 is repealed upon the effective date of these rules.

(9) "Local Mental Health Authority" means the county court or board of county commissioners of one or more counties who operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public agency or private corporation with whom the Division directly contracts to provide the mental health services program area.

(10) "Mental Health Program Area" means the organization of all services for persons with mental or emotional disturbances, operated by or contractually affiliated with, a local mental health authority, in a specific geographic area of the state.

(11) "Mental Health Services Provider" means a corporate, or government entity, which provides a service defined in a Division administrative rule, under a contract or agreement with the Division, or CMHP.

(12) "Non-Inpatient Provider" means an organization not contractually affiliated with the Division, a CMHP, or other contractor of the Division providing services under group health insurance coverage for mental or nervous conditions which seeks or maintains Division approval under ORS 743.556(3).

(13) "Provider" means either a mental health services provider, holding facility, or a non-inpatient provider.

(14) "Service Element" means a distinct service or group of services for persons with mental or emotional disturbances which is defined in administrative rule and is included in a contract or agreement issued by the Division.

(15) "Subcontract" is the document describing and limiting the relationship and obligations between a government or other entity having an agreement or contract with the Division and a third organization (subcontractor) for the purpose of delivering some or all of the services specified in the agreement or contract with the Division.

(16) "Substantial Compliance" means a level of adherence to Division rules applicable to the operation of a service which, while not meeting one or more of the requirements in an exact, literal manner, does not, in the determination of the Division, constitute a danger to the health or safety of any person, is not a willful or a potentially continuing violation of the rights of service recipients as set forth in administrative rules, or will not prevent the accomplishment of the State's purposes in approving or supporting the subject service. "Substantial failure to comply" is used in this rule to mean the opposite of "substantial compliance."

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0150
Applicability of Certificates of Approval

Certificates of Approval are awarded to mental health services providers and non-inpatient providers that are found to be in substantial compliance with applicable administrative rules:

(1) Mental health services providers are required to maintain Certificates of Approval as follows:

(a) Each community mental health program or provider operating under an Intergovernmental Agreement or a direct contract with the Division must maintain a Certificate of Approval as set forth in these rules;

(b) Each local mental health service provider operating under subcontract with a CMHP must maintain a Certificate of Approval as set forth in these rules in order to receive funds administered by the Division through the local subcontract relationship.

(2) Hospitals and other facilities which operate as holding facilities in providing care, custody, and treatment of allegedly mentally ill persons under the emergency provisions of ORS 426.070, 426.140, 426.175 and 426.215 must maintain a Certificate of Approval as set forth in these rules.

(3) A provider not described above which offers services that may be reimbursable under group health coverage as set forth in ORS 743.556 for mental or emotional conditions may seek to obtain a Division Certificate of Approval in order to establish reimbursement eligibility.

(4) Certificates of Approval are not awarded as a substitute for a license such as those required in ORS 443.410 and 443.725 for residential facilities. However, the Division may require such licensed providers to obtain a Certificate of Approval if services exceeding those required for licensure are provided in return for Division financial support as set forth in section (1) of this rule.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0160
Award of Certificates of Approval for New Applicants

(1) County governments and applicants for direct contracts with the Division. Counties not operating under an agreement with the

Division, or those electing to add Division service elements which are not included in their agreement, and other organizations seeking to become direct contractors of the Division following the Division's request for such contractors, may be awarded Certificates of Approval based upon the following:

(a) A plan for the implementation of the proposed services which meets the specifications of the Division;

(b) Written assurance, by an officer with authority to obligate the applicant, that all applicable rules of the Division for operation of the proposed services will be met, or if not, operated in compliance with a waiver awarded by the Division; and

(c) Other reviews, such as those described in OAR 309-012-0190(3), which in the judgment of the Division may assist to predict compliance of the applicant's proposed services with administrative rules;

(d) Following the completion of the application process, and any reviews deemed necessary by the Division, the Division will make one of the following determinations:

(A) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to operate in compliance with applicable administrative rules;

(B) That the applicant may be awarded a Certificate of Approval with specified conditions as described in OAR 309-012-0200; or

(C) That the applicant will not be awarded a Certificate of Approval because it has not demonstrated that it will comply with applicable administrative rules.

(2) Community mental health subcontracted providers, holding facilities, and performing providers:

(a) A provider seeking a Certificate of Approval for the first time, in order to operate as a CMHP subcontractor, performing provider under OAR 309-016-0070, or holding facility shall submit an application to the CMHP in the county in which the service will be offered;

(b) Upon a determination by the CMHP to subcontract with the provider for the purpose of providing a mental health service, for the purpose of operating as a performing provider under OAR 309-016-0070, or as a holding facility, the CMHP shall apply to the Office of Mental Health Services for a Certificate of Approval for the program;

(c) The CMHP application to the Division must include the following:

(A) Provider identifying information including corporate name, address, telephone number, and name of manager or director;

(B) Written assurance from an officer with authority to obligate the applicant that the applicant will operate in compliance with all administrative rules applicable to the services which will be subcontracted to the provider, or a request for a variance to the applicable administrative rules with which the provider will not comply.

(d) The Division may initiate other reviews such as those described in OAR 309-012-0190(3) and may negotiate with the CMHP, ongoing monitoring activities to be conducted to ensure the provider's compliance;

(e) Following the completion of the application process described above, and any reviews deemed necessary by the Division, the Division will make one of the following determinations:

(A) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to comply with applicable administrative rules;

(B) That the applicant may be awarded a Certificate of Approval with specified conditions for action by the applicant for reaching substantial compliance with applicable administrative rules, and/or specific monitoring activities which have been negotiated with the CMHP as described in subsection (2)(d) of this rule;

(C) That the applicant will not be awarded a Certificate of Approval because it has failed to demonstrate that it will comply with applicable administrative rules, or that the kind and amount of monitoring proposed by the CMHP will not assure the applicant's compliance.

(f) Certificates of Approval awarded to CMHP subcontractors are issued jointly between the Division and the CMHP. To be valid, such a Certificate must bear the signature of the Assistant Administrator of the Office of Mental Health Services and the CMHP director.

(3) Non-inpatient providers seeking Division approval for insurance reimbursement purposes as provided in ORS 743.556(3). Non-inpatient providers seeking Division approval for insurance reimbursement purposes may correspond with the Office of Mental Health Services specifically requesting application instructions for Division approval as provided in ORS 743.556(3). Following a review of application materials submitted by the provider, the Division may:

(a) Deny the application, in writing, to the applicant because of a failure to pay the application fee described in subsection (d) of this section; because the application materials demonstrate that the provider does not comply with OAR 309-039-0500 through 309-039-0580; or because of the provider's failure to submit materials specified in the application instructions; or

(b) Following review of the application, the Division may:

(A) Schedule reviews such as those described in OAR 309-012-0190(4) by Division personnel; or

(B) Notify the applicant of other agencies or individuals with whom they may contract for the purpose of conducting a review and providing a report of program compliance to the Division;

(C) Notify the applicant of placement on a waiting list for review when Division staff or other agencies or individuals are available to conduct a review.

(c) Following the reviews in paragraph (b)(A) or (B) of this section, the Division will award or refuse to award a Certificate of Approval to the applicant based on the findings of the review;

(d) The Division may require payment of an application fee and a certification fee by non-inpatient programs applying or reapplying for a Certificate of Approval under these rules, provided the collection of such fees has been authorized for the Division budget by the Legislative Assembly or the Emergency Board.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0170
Award of Certificates of Approval to Providers at the Time These Rules are Adopted

(1) Mental health services providers. Upon adoption of these rules, the Division may issue Certificates of Approval to mental health services providers that are operating under an Intergovernmental Agreement, direct contract, or at the request of the CMHP, to current subcontractors of the CMHP.

(2) Non-inpatient providers described in ORS 743.556(3) and holding facilities. Letters of Approval awarded under ORS 743.556(3) and those awarded to holding facilities which remain in effect at the time these rules are adopted, are the equivalent of a Certificate of Approval. These may be maintained and renewed as Certificates of Approval as set forth in these rules.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0180
Duration and Renewal of Certificates of Approval

(1) Mental health services providers. Unless revoked pursuant to OAR 309-012-0210 or unless otherwise specified on the Certificate, Certificates of Approval for mental health services providers are valid for three years or until the Division conducts a periodic review as set forth in OAR 309-012-0190, whichever is later.

(2) Non-inpatient providers. Certificates of Approval for providers described in ORS 743.556(3) are valid for up to three years or as otherwise specified on the Certificate. When a non-inpatient provider seeks a Certificate of Approval to be in effect at the expiration date of a Letter of Approval or a prior Certificate of Approval, an application conforming to the instructions of the Division must be received no later than 90 days prior to the expiration of the earlier Letter of Approval or Certificate.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0190
Conduct of Periodic and Interim Reviews

(1) Review Schedules:

(a) Periodic reviews of mental health service providers will be routinely conducted every three years;

(b) Periodic reviews of non-inpatient providers approved under ORS 743.556(3) will be conducted following the provider's submission of an application for recertification as set forth in OAR 309-012-0180;

(c) Interim reviews of any provider holding a Certificate of Approval may be conducted at any time at the discretion of the Division, or in the case of a subcontractor of a CMHP, at the discretion of either Division or the CMHP.

(2) Notification of Review. Notification that a review will be conducted, along with all instructions and requests for information from the provider, will be made in writing by the designee of the Assistant Administrator of the Office of Mental Health Services. For reviews of subcontractors initiated by the CMHP, notification and instructions will be made by the designee of the director of the CMHP.

(3) Initiation of Reviews:

(a) Reviews of new applicants, and periodic reviews will be scheduled with at least one month's notice from the Division to the CMHP, direct contractor, or non-inpatient provider. Subcontractors will be notified by the CMHP;

(b) The Division and, in the case of a subcontractor, the CMHP may conduct an interim review without prior notification when there is reason to believe any of the following conditions have occurred or may occur:

(A) Operations of the service provider threaten the health or safety of any person;

(B) The provider may act to alter records or make them unavailable for inspections.

(c) Interim reviews other than those specified in subsection (b) of this section will be initiated with at least two week's notice by the Division to the CMHP or direct contractor.

(4) Review Procedures. The Division, and in the case of reviewing a subcontractor, the CMHP, may employ review procedures which it deems adequate to determine compliance with applicable administrative rules. These procedures may include but are not limited to:

(a) Entry and inspection of any facility used in the delivery of approved services;

(b) A request for the submission to the Division or CMHP, of a copy of any document required by applicable administrative rules or needed to verify compliance with such rules, or access to such documents for on-site review. Such documentation could include, for example, records of utilization and quality assurance reviews, copies of portions of selected consumer records, and copies of staff academic degrees or professional licenses;

(c) The completion by the provider of self-assessment checklists reporting compliance or non-compliance with specific rule requirements; and

(d) Conduct of interviews with, and administration of questionnaires to persons knowledgeable of service operations, including, for example, staff and management of a provider, governing and advisory board members, allied agencies, service consumers, their family members, and significant others;

(e) In the case of subcontracts and reviews initiated by the county, the county may request Division assistance in conducting the reviews.

(5) Reports of Review Findings:

(a) Completion Deadlines. The Division will issue a completed report of review findings, a Certificate of Approval, and any conditions to approval, or denial of approval within 60 days of the completion of an on-site review, or within 60 days of the date of submission of all review materials which have been requested for the purpose of conducting the review, whichever is later;

(b) Content and scope of reports. Reports of reviews will include the following:

(A) A description of the review findings regarding program operations relative to applicable administrative rules, and contract or agreement provisions;

(B) A specification of any conditions set as described in OAR 309-012-0200, which the provider must meet, and the time permitted to meet the conditions;

(C) A statement clarifying the provider's approval status; and

(D) An appendix containing any report of findings or observations clearly qualified as unrelated to the provider's approval status which may be useful as information and recommendations to the service provider or the CMHP.

(c) Transmittal of Reports. Each report shall be issued along with a document of transmission signed by the Assistant Administrator of the Office of Mental Health Services, and any Certificates of Approval being awarded;

(d) Report Distribution. The Division will address and issue reports as follows:

(A) Reports of reviews of a directly operated or subcontracted portion of a community mental health program will be issued to the local mental health authority;

(B) Reports of reviews of direct contractors of the Division will be issued to the signator(s) of the direct contract; and, the Chairperson of the Board of Directors of the contractor;

(C) Reports of reviews of holding facilities which are not subcontractors of a community mental health program, and reviews of non-inpatient providers will be issued to the provider's officer or employer requesting the review.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0200
Establishment of Conditions to the Award of Certificates of Approval

Based upon a finding that a provider does not operate in compliance with an applicable administrative rule, other than as set forth in OAR 309-012-0210(1), the Division may establish conditions to the award and/or continuation of a Certificate of Approval:

(1) Division Discretion. The Division, and, in the case of a subcontractor, the Division and CMHP, may elect to place conditions on approval of a provider in situations in which the alternative would be denial or revocation of approval because of a failure to substantially comply with applicable rules as described in OAR 309-012-0210(2). The decision to employ special conditions rather than revoke or refuse to award approval will be based on criteria such as the following:

(a) The expressed willingness of the provider to gain compliance with applicable rules;

(b) The apparent adequacy of actions proposed by the provider to gain compliance;

(c) The availability of alternative providers to address any service needs that would be unmet if the provider were not allowed conditions to approval as an alternative to revocation or refusal to award a Certificate of Approval;

(d) The provider's historical compliance with Division rules and conditions.

(2) Method of Establishment:

(a) Conditions to approval shall be communicated in writing and issued along with a document of transmission signed by the Assistant Administrator of the Office of Mental Health Services;

(b) Each written condition shall specify the time period allowed to gain compliance and any interim steps for obtaining such compliance.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0210
Certificate Denial or Revocation

(1) Immediate Denial or Revocation. The Division, or in the case of a subcontractor provider, either the Division or the CMHP may refuse to renew or may immediately revoke a Certificate of Approval, without a prior notice or hearing when the applicant or provider:

(a) Has demonstrated substantial failure to comply with applicable rules such that the health or safety of individuals is jeopardized and the applicant fails to correct the noncompliance within the time specified by the Division;

(b) Has demonstrated a substantial failure to comply with applicable rules such that the health or safety of individuals is jeopardized during two reviews within a six-year period;

(c) Has failed to maintain any State of Oregon license which is a prerequisite for providing services that were approved;

(d) Is a county, or direct contractor that has terminated its agreement or contract with the Division for the provision of the approved services, or when the approval is to a subcontract provider of such a county or direct contractor;

(e) Is approved to provide a service as a CMHP subcontractor, whose subcontract is terminated;

(f) Continues to employ personnel who have been convicted of any felony, or a misdemeanor associated with the provision of mental health services;

(g) Falsifies information required by the Division regarding services to consumers, or information verifying compliance with rules; or

(h) Refuses to submit or allow access to information for the purpose of verifying compliance with applicable rules when notified to do so as set forth in OAR 309-012-0190(2), or fails to submit such information following the date specified for such a submission in the written notification.

(2) Denial or Revocation with Notice. Following a Division finding that there is a substantial failure to comply with applicable rules beyond the conditions in section (1) of this rule, such that, in the Division's view the state's purposes in approving the services are not or will not be met, the Division may, with 30 days notice, refuse to award or renew, or may revoke a Certificate of Approval.

(3) Informal Conference. Within ten calendar days following a 30-day notice issued under section (2) of this rule, the Division shall give the provider an opportunity for an informal conference at a location of the Division's choosing. Following such a conference, the Division may proceed with denial or revocation effective on the 30th day following the notice issued under section (2) of this rule, or may approve the provider, or set conditions to approval as described in OAR 309-012-0200 rather than denying or revoking approval.

(4) Hearing. Following issuance of a notice of Certificate revocation or denial, the Division shall provide the opportunity for a hearing as set forth in OAR 309-012-0220.

(5) A county may employ process consistent with the above, or processes adopted by resolution of the local mental health authority for revoking the approval of a subcontract provider.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

309-012-0220
Hearings

(1) Request for Hearing. Upon written notification by the Division of revocation or denial to issue or renew a Certificate, pursuant to OAR 309-012-0210(1) and (2), the provider shall be entitled to a hearing in accordance with ORS Chapter 183. The request for hearing shall include an admission or denial of each factual matter alleged by the Division and shall affirmatively allege a short, plain statement of each relevant affirmative defense the provider may have.

(2) Hearing rights under OAR 309-012-0210(1). The immediate suspension or denial of a Certificate under OAR 309-012-0210(1) is made pending a fair hearing not later than the tenth day after such suspension or denial.

(3) Issue at hearing after immediate suspension or denial pursuant to OAR 309-012-0210(1)(a). The issue at a hearing on Certificate denial or revocation pursuant to this rule is limited to whether the provider was or is in compliance at the end of the time specified by the Division following the finding of substantial failure to comply.

Stat. Auth.: ORS 430.041, 430.640(l) & 430.640(h)
Stats. Implemented:
Hist.: MHD 4-1992, f. & cert. ef. 8-14-92

DIVISION 13

ACCOUNTING AND BUSINESS PRACTICES

Trust Accounts and Patient Funds

309-013-0030
Management of Trust Accounts and Patient Funds in State Institutions

(1) Purpose. This rule establishes standards and procedures to be observed by Superintendents and their employees in the management of trust accounts and patient funds in state institutions, as well as make applications on behalf of patients for Social Security or Veterans Administration benefits or be appointed representative payee for a patient's Social Security or Veterans Administration benefit payments.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 430.041(1) and carries out the provisions of ORS 179.510 to 179.540.

(3) Definitions. As used in this rule:

(a) "Agency trust account" means an account established in the name of a patient by the Superintendent of a state institution under ORS 179.510 to retain funds deposited with the Superintendent by or for the named patient;

(b) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services;

(c) "Patient's Designee" means a person designated by the patient in a state institution in writing to receive duplicate copies of documents sent to the patient relating to the patient's funds;

(d) "Representative or Indirect Payee Trust Account" means a trust account established in the name of a patient by the Superintendent of a state institution or other staff representative or indirect payee to retain the patient's Social Security or Veterans benefits paid to the representative payee;

(e) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton;

(f) "Superintendent" means the executive head of the state institution as listed in subsection (3)(e) of this rule;

(g) "Treatment Team" means the group whose membership consists of professional and direct care staff.

(4) Admission to State Institution. Upon admission or readmission to a state institution, the patient, a guardian or conservator, and the patient's designee, if any, shall be provided with written notices containing the following information:

(a) The patient's obligation under state law to reimburse the state for the actual cost of the patient's care and maintenance, according to the patient's ability to pay, whichever is less;

(b) The patient's option to place money in either an agency trust account or other suitable depository outside the state institution. The agency trust account withdrawal and deposit procedures and the Superintendent's powers with respect to such accounts shall be explained therein;

(c) In the event the patient requests the state institution to forward funds outside the state institution to other than a bank or secure financial institution and, in the clinical judgment of the Superintendent, the patient is not able to understand the implications of the patient's request, the Superintendent shall provide notice that the patient's funds have been placed in an agency trust account; and a proceeding to have a conservator appointed will be commenced within ten days from the date of the notice;

(d) Copies of all relevant state laws and rules regarding handling of patient funds and institutional reimbursement shall be made available to the patient, a guardian or conservator, and the patient's designee on request;

(e) The patient, a guardian, or a conservator may designate another responsible person to be representative or indirect payee for benefits and/or to receive duplicate copies of all further documents detailing procedures, agency trust account transactions, applications by the Superintendent for patient benefits, or documents otherwise related to the institutional reimbursement process as it affects the patient. A form for designating one other person to receive such documents shall be provided upon request.

(5) Agency Trust Account Transactions. A monthly statement indicating the deposits and withdrawals during the prior month of the agency trust account shall be delivered to the patient, a guardian or conservator, and the patient's designee, if any.

(6) Representative or Indirect Payee Trust Account Transactions. A monthly statement indicating the deposits and withdrawals during the prior month of the representative or indirect payee trust account shall be delivered to the patient, a guardian or conservator, and the patient's designee, if any.

(7) Determination of Patient's Capability to Manage Funds:

(a)(A) If an investigation indicates the patient is incapable of managing his or her funds, the relevant Social Security Administration or Veterans Administration form and recommendation shall be forwarded to the Superintendent's office. Upon receiving the form, the Superintendent or the Superintendent's designee shall cause notice of the proposed application to be sent as indicated in section (8) of this rule;

(B) Inquiries may be made of attending doctors and other reliable persons who deal with the patient frequently.

(b) When, after investigation, in the opinion of the Superintendent, a patient is or has become incompetent and/or incapable of making an informed consent or incapable of managing funds, and there

is no person legally responsible for the patient (such as a guardian or conservator), the Superintendent may:

(A) Apply to have a representative or indirect payee appointed under section (8) of this rule; and/or

(B) Commence proceedings to establish a guardianship or conservatorship.

(8) Application for Benefits or Notification of Incapacity to Manage Funds:

(a) When, after investigation pursuant to section (7) of this rule, the Superintendent determines that such a step would be in the best interests of the patient, the Superintendent or the Superintendent's designee may apply for Social Security or Veterans benefits on behalf of a patient. Before each application, the patient, a guardian or conservator, and the patient's designee, if any, shall be mailed notice of the proposed application. Notice shall include the following:

(A) A statement of the intention to apply for such benefits;

(B) A copy of the proposed application, indicating the reason for the application and the evidence relied upon in determining that an application is warranted;

(C) If the applicant seeks to be selected as representative or indirect payee, a statement that this will mean that the representative of the federal agency concerned will determine whether it is in the best interests of the patient that a payee be appointed;

(D) A statement that the patient, a guardian or conservator, or the patient's designee, if any, may submit to the Superintendent a written statement including written evidence why the application should not be made. This statement and evidence must be submitted not more than 12 days from the date of the notice; and

(E) A statement that any such written statement submitted on behalf of the patient and received within the time specified shall be considered by the Superintendent or other official in the decision to submit the proposed application.

(b) After such notice has been given, and either:

(A) Twelve days have elapsed without response from the patient, a guardian or conservator, or the patient's designee, if any; or

(B) The statement or written evidence submitted pursuant to paragraph (8)(a)(D) of this rule has been received, the Superintendent or the Superintendent's designee shall consider all the evidence submitted and decide whether an application would be in the patient's best interest. If it is decided that the application should be made, the patient, a guardian or conservator, and the patient's designee, if any, shall receive copies of the application and any supporting materials thereof.

(c) The response of the Social Security Administration or Veterans Administration to the application shall likewise be forwarded, along with information concerning the rights of patients and other interested persons regarding Social Security or Veterans Administration benefits, to the patient, a guardian or conservator, and the patient's designee, if any.

(9) Deposit of Social Security Administration and Veterans Administration Checks:

(a) Checks for which the patient is the payee must be deposited directly into the patient's agency trust account if the patient has elected to have such an account. In the event the patient has elected a suitable depository outside the state institution, arrangements for forwarding the patient's funds to that depository are the responsibility of the patient, a guardian or conservator, or the patient's designee, if any. Notification of receipt of the check and the deposit thereof in the agency trust account shall be made in the next monthly statement to the patient, a guardian or conservator, and the patient's designee, if any. When such Social Security or Veterans funds are deposited in the agency trust account, the funds shall be clearly designated as Social Security Administration or Veterans Administration benefit money;

(b) Social Security or Veterans funds in the agency trust account may be taken to pay the patient's bill for care and maintenance at the state institution only when the patient (if not judicially or factually incompetent) or the patient's guardian or conservator has executed a written consent for that particular transaction. "Blanket" or continuing consents will not be honored insofar as they affect Social Security or Veterans benefits;

(c) Checks payable to the Superintendent or the Superintendent's designee as indirect or representative payee may be deposited directly into the patient's representative or indirect payee trust account. Notification of receipt of the check and the deposit thereof in the representative or indirect payee trust account shall be made in the next quarterly statement to the patient, a guardian or conservator, and the patient's designee, if any.

(10) Discharge from State Institution. At or before discharge from a state institution, each patient, a guardian or conservator, and the patient's designee, if any, shall be provided with a statement containing the following information:

(a) The patient's continuing obligation under state law to reimburse the state for the actual cost of the patient's care and maintenance, according to the patient's ability to pay;

(b) The patient may contest payments made to the State of Oregon for charges for institutional care and maintenance during the period of recent hospitalization;

(c) Copies of the relevant state laws and administrative rules regarding the patient's post-discharge right to contest payments made to the State of Oregon for charges for institutional care and maintenance will be made available to the patient or other interested party on request;

(d) Copies of monthly statements of transactions concerning the activity in the patient's agency trust account and quarterly statement of representative or indirect payee trust account may be made available to the patient, legal representative, or other designated person not otherwise prohibited from seeing them upon request.

(11) Incapacity to Perform:

(a) The patient's treatment team at the state institution may certify in writing that a patient's mental illness or mental retardation has rendered the patient incapable of even minimal understanding of any of the notices provided for in this rule. Notwithstanding any other provision of this rule, should such certification occur, the Division or state institution is not required to provide the patient with the various forms of notice otherwise required by this rule;

(b) Certification that a patient's mental illness or mental retardation renders the patient incapable of understanding the notice provided by this rule shall be reviewed and redetermined annually by the Superintendent as part of the patient's annual plan of care.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 42(Temp), f. & ef. 9-9-76; MHD 9-1980(Temp), f. & ef. 4-18-80; MHD 16-1980, f. & ef. 6-24-80

Agency Payroll System for Patient and Resident Workers in State Institutions

309-013-0035
Purpose and Statutory Authority

(1) Purpose. The Pay for Patient and Resident Workers Program was established to support the goals or the patient's or resident's treatment/training plan. These rules establish standards and procedures for administering the agency payroll system for patient and resident workers in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040, and carry out the provisions of ORS 179.440, 426.385 and 427.031.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0040
Definitions

As used in these rules:

(1) "Appointment Notice" means the form used at the institution to enter a patient or resident worker into the agency payroll system.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Patient Worker" means a person in a state institution for the mentally or emotionally disturbed who performs work for pay that is of therapeutic benefit to the patient.

(4) "Resident Worker" means a person in a state institution for the mentally retarded and other developmentally disabled who performs work for pay that is of training benefit to the resident.

(5) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0045
Wage Standards

(1) State institutions will use the first step of the state wage scale, which corresponds with the existing state classification of the job to be performed, to calculate payments for work performed by patient and resident workers.

(2) Patients and residents whose productivity is lower than the productivity normally required to perform the job will be paid a percentage of the first step amount. The percentage will be commensurate with the level of productivity as calculated by the institution, and consistent with the Personnel Division Compensation Plan.

(3) Patients and residents who are paid an amount equal to less than the first step of the state wage scale for the existing classification will be allowed, upon request, to review their record with regard to the calculation of their productivity level.

(4) Wages will be paid based either on the time spent doing the job or on the rate established for completing a specific task multiplied by the number of tasks completed.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0055
Hiring Procedure

(1) Prior to employment, all patient and resident workers must be informed verbally, and in writing, of their rights with respect to their working relationship with the state institution. Those rights are as follows:

(a) To receive reasonable compensation for all work performed, other than personal housekeeping chores;

(b) To receive overtime compensation for work performed in excess of an eight hours per day or 40 hours per week;

(c) To refuse any work except personal housekeeping chores and, that which is essential for their treatment or training;

(d) To review their productivity rating if less than 100 percent.

(2) The institution must complete an appointment notice for each patient and resident worker.

(3) Each patient worker and resident worker must complete a Form W-4.

(4) Each patient and resident worker without a Social Security number must apply for and receive one prior to employment.

(5) Each patient and resident worker who receives Social Security benefits (SSI or SSD), or is eligible for Title XIX, must be informed that an earnings record will be sent to those offices for possible payment adjustment.

(6) Each patient and resident worker under 18 years of age must have a work permit prior to employment.

(7) If applicable, the patient or resident worker must sign, in the presence of a witness, the Notice to Patient/Resident Worker form, (MHD-ADM-0169), prior to beginning work. No billing for cost of care based on agency earnings will predate the delivery of this notice.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

309-013-0060
Payroll Procedure

(1) Each state institution will use a gross payroll system for processing the agency payroll for patient and resident workers. Biennial budgets for agency payroll will be based on expected gross payroll expenses.

(2) The work supervisor will keep a record of each patient or resident worker's work times and/or specific tasks completed.

(3) Each institution shall adopt written procedures, approved by the Division Administrator, to prepare, distribute, and account for agency payroll payments.

(4) Payroll records will be maintained in accordance with the appropriate record retention requirements of the Secretary of State's Archives Division.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 2-1981, f. & ef. 6-25-81; MHD 2-1985, f. & ef. 2-7-85

Fraud and Embezzlement

309-013-0075
Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures for handling cases of fraud and embezzlement involving Mental Health and Developmental Disability Services Division employees working in the central office or state institutions, persons working under personal service contracts with the Division, and service providers and subcontractors of service providers contracting with the Division.

(2) Statutory Authority. These rules are authorized by ORS 179.040 and 430.041, and carry out the provisions of ORS 430.021(2).

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0080
Definitions

As used in these rules:

(1) "Central Office" means all organizational elements of the Mental Health and Developmental Disability Services Division which are not a part of a state institution.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Embezzlement" means any action to willfully take or convert to one's own use, money or property of another, which the wrongdoer acquired lawfully through some office or employment or position of trust.

(4) "Fraud" means any action by an individual to knowingly, willfully and with deceitful intend take or use for their own personal gain money or property which does not belong to them.

(5) "Service Provider" means a public or private community agency or organization that provides a particular mental health service (such as preschool services for the developmentally disabled, a detoxification center, or a day treatment program) approved by the Division. An agency organization may provide more than one service element, and more than one agency or organization in a county may provide the same service element.

(6) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0085
Reporting of Suspected Fraud and Embezzlement

(1) Upon discovery, all cases of suspected fraud and embezzlement related to the central office shall be referred, along with all related information, to the Administrator. The Administrator shall review the case, call upon appropriate sources to investigate, and notify appropriate authorities.

(2) In case of suspected fraud or embezzlement involving a state institution, the superintendent of the institution shall review the case, call upon appropriate sources to investigate, and notify appropriate authorities. All cases under review shall be reported to the Administrator.

(3) Each service provider contracting with the Division shall report in writing the details of all cases of suspected fraud and embezzlement involving its employees and/or the employees of its subcontractors to the Division's Administrator not later than one working day after the date the alleged activity comes to their attention. The report shall describe the incident and action being taken to resolve the problem.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0090
Investigation of Suspected Fraud and Embezzlement

(1) In cases of suspected fraud and embezzlement involving funds and resources of the Division:

(a) The Administrator shall begin the investigation immediately and may, in the course of investigation, call upon the services of appropriate law enforcement agencies, the Attorney General, the Division

Audit Unit, and/or other who may be of assistance in developing the case;

(b) A service provider which has contracted with the Division is responsible for developing cases of suspected fraud and embezzlement involving its employees and/or the employees of its subcontractors, and is responsible for referral to the proper authorities. However, the Division may assume control of any case not handled to the Division's satisfaction.

(2) In cases of suspected fraud and embezzlement which do not involve funds and resources of the Division:

(a) The aggrieved parties shall seek their own resolution, and the Division will not become involved in development of the case or prosecution, except it may intervene in cases involving resources of clients of service providers;

(b) The Division shall review the case to determine whether the lack of internal controls which allowed fraud or embezzlement to occur might also endanger Division resources. If that possibility exists, the service provider shall be required to adopt and follow procedures which the Division decides are needed to minimize chances for recurrence of the fraud or embezzlement. Failure of the service provider to adopt and follow such procedures shall constitute grounds for refusing to contract with the service provider in the future, and for terminating the existing contract.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0095
Consequences of Failure to Adopt Procedures

Failure of a service provider to adopt and follow procedures which the Division decides are needed to minimize chances for fraud and embezzlement of Division resources shall constitute grounds for terminating any contract between the Division and that service provider. If the service provider is a subcontractor of a service provider contracting with the Division, then such failure on the part of the subcontractor shall constitute grounds for stipulation by the Division that no Division managed funds be used for payment to that subcontractor.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0100
Disclosure Requirement

Disclosure must be made to the Division before a contract is entered into, or at the time it becomes known, of the name of any person who has ownership or control interest of five percent or more, or is an officer, director, agent, or managing employee, and has been convicted of a criminal offense related to the involvement of such person in any such program, including theft of patient funds. Failure to make this disclosure shall constitute grounds for terminating that contract.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

309-013-0105
Disciplinary Action

Fraud or embezzlement of Division resources and/or patient or resident funds committed by Division employees shall constitute grounds for disciplinary action. The type and extent of disciplinary action will be determined in accordance with the Division's collective bargaining agreements and "Personnel Relations Law, Personnel Rules and Personnel Policies." Notwithstanding any portion of these rules, existing agreements with unions representing the employee(s) involved, governing complaint investigation, shall be observed.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 18-1982, f. & ef. 8-6-82

Audit Guidelines

309-013-0120
Purpose and Statutory Authority

(1) Purpose. These rules establish a Mental Health and Developmental Disability Services Division (MHDDSD) procedure for audits of community mental health programs, mental health organizations and their subcontractors and vendors and any service provider agreeing to offer services through direct contract with the MHDDSD. These rules also establish basic record keeping standards for programs subject to audit under these rules, establish procedures for appealing audit findings, and set out a process to implement the findings of the final audit report.

(2) Statutory Authority. These rules are authorized by ORS 409.050, 430.041 and 430.640 and are promulgated to enable the Mental Health and Developmental Disability Services Division to carry out its responsibilities under ORS 414.018 to 414.024 and 430.610 to 430.695.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0130
Definitions

(1) "Audit" means the examination of documents, records, reports, systems of internal control, accounting and financial procedures, and other evidence for one or more of the following purposes:

(a) To ascertain whether the financial statements present fairly the financial position and the results of financial operations of the fund types and/or account groups in accordance with Generally Accepted Accounting Principles and federal and state rules and regulations;

(b) To determine compliance with applicable laws, rules, regulations and contract provisions;

(c) To review the efficiency and economy with which operations are carried out; and

(d) To review effectiveness in achieving program results.

(2) "Capital Construction" is an expenditure related to construction or remodeling of physical facilities with a projected cost of $250,000 or more.

(3) "Capital Improvement" is an expenditure related to construction or remodeling of physical facilities with a projected cost of more than $5,000 but less than $250,000.

(4) "Capital Outlay" are purchases of equipment and tangible personal property of a non-expendable nature which have a useful life of more than one year. The minimum dollar threshold for determining if a purchase is capital outlay can not exceed the amount set for state purchases of capital outlay. The current threshold for the State of Oregon is $5,000, however, a lessor amount may be used.

(5) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disturbances, developmental disabilities or chemical dependency, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(6) "Direct Contractor" means a person or organization which operates under a direct contract with the Mental Health and Developmental Disability Services Division to provide services to persons with mental or emotional conditions and/or developmental disabilities.

(7) "Internal Auditor" means auditors within the Audit Unit of the Mental Health and Developmental Disability Services Division.

(8) "Internal Control Structure" means the plan of organization including all of the methods and measures adopted within a business to safeguard its assets, check the accuracy and reliability of its accounting data, and promote operational efficiency and adherence to management's policies.

(9) "Local Mental Health Authority (LMHA)" means the county court or board of county commissioners of one or more counties who choose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation which contracts with MHDDSD to operate a CMHP for that county.

(10) "Mental Health and Developmental Disability Services Division (MHDDSD or Division)" means the Department of Human Services (DHS) Agency responsible for the administration of the State mental health and developmental disability services to persons who qualify for certain programs under federal and state laws, rules and regulations.

(11) "Mental Health Organization (MHO)" means a Prepaid Health Plan under contract with MHDDSD to provide covered services under the Oregon Health Plan Medicaid Demonstration Project. MHOs can be Fully Capitated Health Plans (FCHPs), CMHPs or private MHOs or combinations thereof.

(12) "Non-allowable Expenditures" means expenditures made by a contractor or subcontractor of the Mental Health and Developmental Disability Services Division which are not consistent with relevant federal and state laws, rules, regulations and contract provisions. To be allowable, expenditures must be necessary and reasonable for the proper and efficient performance of the contracted services. If only state funds are involved, expenditures will be evaluated based on state laws and rules, the contract provisions, and whether they are necessary and reasonable for the proper and efficient performance of the contracted services. When federal funds are involved, determination of allowable expenditures includes, but is not limited to, those rules and regulations itemized and referred to in applicable Office of Management and Budget circulars.

(13) "Office of Medical Assistance Programs (OMAP)" means the office of the Department of Human Services responsible for coordinating the Medical Assistance Program within the State of Oregon.

(14) "Reasonable Cost" means a cost that in nature or amount does not exceed that which would be incurred by a prudent person under the circumstance prevailing at the time the decision was made to incur the cost. Consideration shall be given to whether the cost is of a type generally recognized as ordinary and necessary for the operation of the organization; what restraints or requirements exist such as those imposed by factors of generally accepted sound business practices, federal and state laws and regulations, and terms and conditions of the contract; whether the individuals concerned acted with prudence in the circumstances, considering their responsibilities to the organization, their employer, their clients, the public and the governments; and whether significant deviations from the organization's established practices unjustifiably increase costs.

(15) "Service Element" means a distinct service or combination of services as defined in Part III of the Intergovernmental Agreement for persons with mental or emotional conditions and or developmental disabilities provided in the community setting by a contract with the MHDDSD or through a subcontract with a local mental health authority.

(16) "Service Provider" means a public or private community agency or organization contracted by the MHDDSD that provides recognized mental health or developmental disability service(s) and is approved by the MHDDSD or other appropriate agency to provide these service(s). For the purpose of this rule, "provider" or "program" is synonymous with "service provider."

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0140
Scope and Application of the Rule

Under these rules, the MHDDSD may audit any service provider that provides any part of the community mental health program including the community mental health program itself, Mental Health Organizations providing services under the Oregon Health Plan including subcontractors and vendors providing mental health services, or any direct contractor. The scope of the audit shall include only MHDDSD funds or related matching funds. However, MHDDSD may include other funds in its tests to the extent necessary to audit MHDDSD funds or matching funds. These rules shall be read and applied consistently with OAR 309-014-0000 (Community Mental Health Contractors) or the Office of Medical Assistance Programs general rules (OAR 410-120-0000 through 410-120-1980) when these are applicable.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0150
Revenue

(1) A service provider shall maintain a revenue account for each income source which results from the operation of the service or is used to support the service. For example, separate revenue accounts shall be established for each service element for which the provider receives payment from MHDDSD or the Office of Medical Assistance Programs, direct federal payments, donations, fees, interest earned, rentals collected from subleases and parking lots, sales of capital equipment, training grants or any other source of income.

(2) Only cash revenue may be used to match state funds unless the MHDDSD gives prior authorization in writing to use contributed services or property to match state funds.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0160
Expenses

(1) A service provider subject to audit under these rules shall keep its accounting records consistent with Generally Accepted Accounting Principles. Accounting records shall be retained for three years from the date of the expiration of the MHDDSD's agreement or from the finalization of an audit, whichever comes later. Allocation methods for expenses shall be documented. Relevant calculations representing allocations shall be shown. The allocation method shall reasonably distribute expenses which are shared by service providers or service elements. Charges assessed against a service provider by a related organization shall be justified by the related organization as to the method and reason for relevant cost allocation. The expense invoice shall list the location where services and supplies purchases are delivered for any item in excess of $1,000.

(2) Record requirements for Personal Services:

(a) Reports reflecting the distribution of labor of each employee must be maintained for all staff members, professional and nonprofessional, whose compensation is charged in whole or in part to MHDDSD funds. To support the allocation of indirect costs, such reports must also be maintained for other employees whose work involves two or more functions or activities if a distribution of their compensation between such functions or activities is needed in the determination of the organization's indirect cost rate(s). Reports maintained to satisfy these requirements must meet the following standards:

(A) The reports must reflect an after-the-fact determination of the actual activity of each employee. Budget estimates (i.e., estimates determined before the services are performed) do not qualify as support for charges to MHDDSD funds;

(B) Each report must account for the total activity for which employees are compensated and which is required in fulfillment of their obligations to the organization;

(C) The reports must be signed by the individual employee, or by a responsible supervisory official having first-hand knowledge of the activities performed by the employee, to attest that the distribution of activity represents a reasonable distribution of the actual work performed by the employee during the periods covered by the reports;

(D) The reports must be prepared at least monthly and must coincide with one or more pay periods;

(E) Periodic time studies, in lieu of ongoing time reports, may be used to allocate salary and wage costs. However, the time studies used must meet the following criteria:

(i) A minimally acceptable time study must encompass at least one full week per month of the cost reporting period;

(ii) Each week selected must be a full work week (e.g., Monday to Friday, Monday to Saturday or Sunday to Saturday);

(iii) The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period three of the 12 weeks in the study must be the first week beginning in the month, three weeks the second week beginning in the month, three weeks the third and three weeks the fourth;

(iv) No two consecutive months may use the same week for the study, (e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months);

(v) The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years;

(vi) The time study must apply to a specific provider. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

(b) Any person being compensated for services to a service provider who is not an employee of the organization shall have a written contract with the service provider. The contract shall set forth the

specific services being purchased, the contract time period, the rate at which compensation will be paid and an hourly rate where applicable.

(3) Record Requirements for Capital Expenditures:

(a) Depreciation for capital outlay, capital improvements, and capital construction shall be documented in a depreciation schedule. The depreciation schedule at a minimum shall include a description of the asset, date of acquisition, cost basis, depreciation method, estimated useful life, annual depreciation expense and accumulated depreciation.

(b) Any capital expenditures purchased by a service provider using MHDDSD funds shall be listed on an inventory system showing location of item and reference to purchase invoice and payment receipt location. The inventory shall be checked annually and verification of the inventory list signed by the inventory control person. All capital items purchased with MHDDSD funds must be used in an MHDDSD approved program.

(4) Reasonable Procedures will be established to ensure the security of cash, blank checks, purchase orders, check protector machines, and signature stamps.

(5) A service provider must expend funds consistent with an intergovernmental agreement or direct contract, these rules, the required program or licensing rule, and federal and state requirements. For service elements contracted with a predetermined rate, MHDDSD funds not used in delivering the service of the required quantity and quality shall be classified as carryover. Carryover of MHDDSD administered funds shall be spent for MHDDSD services. These funds shall be kept in restricted accounts in the financial records. Funds spent on unallowed costs shall be considered noncompliance and shall be returned to MHDDSD.

(6) All travel expenses shall be supported by a system of authorized trip reports, receipts, and/or other documentation. Authorization is indicated by approval of the travel expenditure by the Director (or person with delegated authority) of the service provider.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0170
Audit Process and Reports

(1) Any person, organization, or agency, including MHDDSD, may request an audit of a community mental health program or any service provider offering a service thereunder or any direct contractor by submitting an audit request in writing to the MHDDSD Internal Audit Unit Coordinator. The request shall clearly identify the service provider to be audited, setting forth its name, location, program director, the period for which the audit is requested and the reason for the request.

(2) The Internal Audit Unit Coordinator shall review the request and arrange for scheduling if an audit is considered appropriate. The Internal Audit Unit Coordinator shall notify appropriate Assistant Administrators of the audit schedule.

(3) The Assistant Administrator of the MHDDSD for the Office of Finance has the discretion to notify the appropriate community mental health program director of the scheduled audit in advance. The MHDDSD retains the right to perform an audit without prior notice to the subject service provider.

(4) Upon completion of the audit, the Internal Audit Unit Coordinator shall prepare a report setting forth the findings, recommendations, and auditee responses where applicable. Audit work papers shall be available showing the details of the audit findings.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0180
Disposition of Audit Findings

(1) To the extent an audit documents non-allowable expenditures in non-capitated programs, the MHDDSD shall recover such funds.

(2) To the extent an audit report evidences non-compliance with applicable program and/or licensing rules, the audit findings may be referred to the Administrator of the MHDDSD to assess civil penalties, where applicable, or for other corrective action deemed necessary by the program office.

(3) Notwithstanding any other provisions of these rules, to the extent an audit report reveals non-compliance with Generally Accepted Accounting Principles or these rules, MHDDSD may require corrective action to bring the deficiencies into compliance with state and federal rules and regulations. Non-compliance which results in substantial misrepresentation of financial activities may result in termination of the license and/or contract upon consultation with MHDDSD program offices and/or the local mental health authority.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0190
Provider Appeals

(1) A provider may appeal certain decisions affecting the provider by making a written request to the MHDDSD Assistant Administrator for the Office of Finance. The request must state whether the provider wants an administrative review, and/or a contested case hearing, as outlined in the OMAP General Rules OAR 410-120-1560, Provider Appeals, through 410-120-1840, Provider Hearings-Role of Hearings Officer. If the subject service provider decides to appeal the audit, it shall set forth in writing the reasons for its appeal within 30 days of receipt of the report.

(2) When MHDDSD seeks to recover funds under these rules, MHDDSD shall negotiate the terms and conditions of repayment with the audited service provider, after consultation with the community mental health program director or the MHO director (if applicable).

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0200
Basic Accounting Records

A service provider subject to audit under these rules shall maintain a chart of accounts that defines all items included in determining the cost for each service element. The chart of accounts shall list all revenues and expense accounts. The organization shall have bank deposit records and documentation to verify the source of revenue. Revenue and expense accounts, with related asset, liability, and equity accounts, shall account for all expenditures related to delivery of the service. All basic accounting records shall be retained for at least three years following the expiration of the contract or from the finalization of an audit including any appeal, whichever is later.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0210
Internal Controls

Establishing and maintaining an internal control structure is the responsibility of the service provider. Effective internal controls are considered essential to achieving the proper conduct of business with full accountability for the resources made available. Internal controls shall be implemented and maintained to provide reasonable assurance that:

(1) The provider identifies, assembles, classifies, records, analyzes, and reports its transactions in conformity with Generally Accepted Accounting Principles or appropriate regulatory requirements for preparing financial statements and other required financial reports;

(2) Losses or misappropriations of assets due to errors or irregularities in processing transactions and handling the related assets are prevented or detected;

(3) Noncompliance with applicable federal and state laws and rules and regulations and terms of the contract is prevented or detected;

(4) State and federal funds are reasonably, prudently and economically spent; and

(5) All costs are appropriately allocated among programs, departments, and other benefiting units.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

309-013-0220
Independent Audit Reports

The MHDDSD may, in its discretion, accept an independent audit, in lieu of an MHDDSD audit, if it determines the workpapers and procedures of the independent auditor meet Government Auditing Standards (where applicable), Generally Accepted Auditing Standards and other audit standards which may be adopted by the MHDDSD.

Stat. Auth.: ORS 409.050, 430.041 & 430.640
Stats. Implemented: ORS 414.018 - 414.024 & 430.610 - 430.695
Hist.: MHD 9-1978, f. & ef. 12-11-78; MHD 15-1998, f. 8-12-98, cert. ef. 9-1-98, Renumbered from 309-013-0020

DIVISION 14

COMMUNITY MENTAL HEALTH PROGRAMS

General Administrative Standards for Mental Health Division Community Mental Health Contractors

309-014-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe general administrative standards for Mental Health and Developmental Disability Services Division community mental health and developmental disability services contractors and their component parts.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS Chapter 430.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; MHD 14-1982, f. & ef. 7-7-82, Sections (3) thru (13) Renumbered to 309-014-0005 thru 309-014-0040; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Services, and Administrator for Mental Health and Developmental Disability Services Division.

(2) "Client" means a person receiving services under these rules.

(3) "Community Mental Health and Developmental Disability Advisory Committee" means the advisory committee to a local mental health authority.

(4) "Community Mental Health and Developmental Disability Contractor" means an entity which provides or contracts for a distinct service or group of services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated in the community under a contract or a subcontract with the Mental Health and Developmental Disability Services Division.

(5) "Community Mental Health and Developmental Disability Contractor Budget" means the financial plan of projected expenditures and projected revenues for community mental health and developmental disability service elements submitted by the local mental health authority.

(6) "Community Mental Health and Developmental Disability Contractor Plan" means the plan for community mental health and developmental disability service elements submitted by the local mental health authority.

(7) "Community Mental Health and Developmental Disability Program" means an entity that is responsible for planning and delivery of services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse in a specific geographic area of the state under a contract with the Mental Health and Developmental Disability Services Division or a local mental health authority.

(8) "Community Mental Health and Developmental Disability Program Area" means the organization of all services for persons with either mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, or alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under a contract with the Mental Health and Developmental Disability Services Division.

(9) "Community Mental Health and Developmental Disability Program Director" means the director of a community mental health and developmental disability program which operates or contracts for all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems under the omnibus contract with the Mental Health and Developmental Disability Services Division.

(10) "Developmental Disability Services" means services for people with developmental disabilities as defined by the Division in administrative rule or contract terms.

(11) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(12) "Local Mental Health Authority" means the county court or board of county commissioners of one or more counties who operate a community mental health and developmental disability program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health and developmental disability program, the board of directors of a public or private corporation.

(13) "Local Revenues" means all money, other than state or federal grant or contract funds, expended by a local mental health authority and any of its subcontractors for community mental health and developmental disability services and included in the approved community mental health and developmental disability contractor plan and budget. However, federal funds expended for alcoholism treatment and rehabilitation services provided under ORS 430.345 to 430.380 in accordance with ORS 430.359(3) by community mental health and developmental disability contractors shall be considered local revenues.

(14) "Omnibus Contract" means the Financial Assistance Grant Agreement or contract between the Mental Health and Developmental Disability Services Division and a local mental health authority for all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated in a specific geographic area.

(15) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services provided by the community mental health and developmental disability contractor.

(16) "Service Element" means a distinct service or group of services for person with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated in the community under a contract with the Mental Health and Developmental Disability Services Division, or under contract with a local mental health authority.

(17) "Service Provider" means an entity or person that delivers services funded wholly or in part by the Division under a contract with a community mental health and developmental disability program, a local mental authority, or the Division.

(18) "State Institution" means Oregon State Hospital in Portland and Salem, and Eastern Oregon Psychiatric Center and Training Center in Pendleton.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(3), MHD 14-1982, f. & ef. 7-7-82; MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00 cert. ef. 9-16-00

309-014-0010
Purpose of a Community Mental Health and Developmental Disability Program

The purpose of a community mental health and developmental disability program is to provide a system of appropriate, accessible, coordinated, effective, efficient services to meet the mental health needs of the citizens of the community.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(4), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0015
Division Responsibility for Community Mental Health and Developmental Disability Services

The Division shall assist the local mental health authority in establishing and operating community mental health and developmental disability services and shall integrate such services with other mental health system components in the state by:

(1) Assessing needs for community mental health and developmental disability services in the state.

(2) Identifying priorities among needs and preparing state plans for community mental health and developmental disability services.

(3) Conducting the Division's activities in the least costly and most efficient manner so that delivery of services to the mentally or emotionally disturbed, mentally retarded and developmentally disabled, alcohol abuser, alcoholic, drug abuser and drug-dependent persons shall be effective, coordinated and integrated with other services within the Oregon Department of Human Services.

(4) Establishing and enforcing minimum standards for community mental health and developmental disability services.

(5) Obtaining resources and contracting with local mental health authorities for the operation of community mental health and developmental disability service.

(6) Subject to the availability of funds, providing public information, program consultation, technical assistance, and training concerning community mental health and developmental disability services.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(4) & (7), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0020
Standards for Management of Community Mental Health and Developmental Disability Programs

Each community mental health and developmental disability contractor providing a community mental health and developmental disability program under an omnibus contract with the Division is required to meet the following standards for management:

(1) Community Mental Health and Developmental Disability Program Director:

(a) The community mental health and developmental disability program director shall be a full time employee of the local mental health authority or the public or private corporation operating the community mental health and developmental disability program;

(b) The community mental health and developmental disability program director shall meet the following requirements:

(A) Hold at least a master's degree in a behavioral, social, health science, special education, public administration, or human service administration; and

(B) Have a minimum of five years of experience in human services programs, two of which are in community mental health and developmental disability and two of which are program managerial experience in human services; and

(C) Present references documenting experience, training, and ability to manage a community mental health and developmental disability program.

(c) When the position of community mental health and developmental disability program director becomes vacant, an interim director shall be appointed to serve until a permanent director is appointed.

(2) Program Management for Developmental Disability Services:

(a) Program Manager. The local mental health authority or the public or private corporation operating the community mental health and developmental disability services program shall designate a full-time employee who will, on at least a part-time basis, be responsible for management of developmental disability services.

(b) Program Manager Qualifications. The program manager for developmental disability services shall meet the following qualifications for employment:

(A) Hold at least a bachelor's degree in a behavioral, social, health science, special education, public administration, or human service administration; and have a minimum of four years experience, with at least two of those in developmental disability services, that provided recent experience in program management, fiscal management, and staff supervision.

(B) On an exceptional basis, the county may hire an individual who does not meet these program manager qualifications if the county and the Division have mutually agreed on a training and technical assistance plan which assures that the individual will quickly acquire all needed skills and experience.

(C) When the position of program manager for developmental disability services becomes vacant, an interim program manager shall be appointed to serve until a permanent program manager is appointed. The community mental health and developmental disability services program shall request a variance as provided in these rules if the individual(s) appointed interim program manager do not meet the qualifications and the term of the appointment(s) total more than 180 days.

(c) Management Functions. In addition to other duties as may be assigned in the area of developmental disability services, the community mental health and developmental disability services program shall, at a minimum, assure the following duties are performed:

(A) Develop plans as may be needed to provide a coordinated and efficient use of resources available to serve people with developmental disabilities;

(B) Develop positive and cooperative working relationships with families, advocates, service providers, the Division, and other state and local agencies with an interest in developmental disability services;

(C) Develop programs funded by the Division to encourage pursuit of defined program outcomes and monitor the programs to assure service delivery that is in compliance with related contracts and applicable local, state, and federal requirements;

(D) Assure collection and timely reporting of information as may be needed to conduct business with the Division, including but not limited to information needed to license foster homes, to collect federal funds supporting services, and to investigate complaints related to services or suspected client abuse; and

(E) Develop and assure use of procedures that attempt to resolve disputes and grievances involving persons or organizations that are associated with developmental disability services.

(d) Management Plan. The community mental health and developmental disability services program shall maintain a plan assigning responsibility for the management functions and duties described in this section. The community mental health and developmental disability services program shall assure that the functions and duties are assigned to people who have the knowledge and experience necessary to perform them.

(3) Community Mental Health and Developmental Disability Advisory Committee. Each community mental health and developmental disability program shall have a mental health and developmental disability advisory committee appointed by the local mental health authority:

(a) The committee shall meet at least quarterly;

(b) The membership of the committee shall be broadly representative of the community, with a balance of age, sex, ethnic, socioeconomic, geographic, professional and consumer interests represented. Membership shall include advocates for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems;

(c) The Community Mental Health and Developmental Disability Advisory Committee shall advise the local mental health authority and the community mental health and developmental disability program director on community needs and priorities for services and shall assist in planning and in review and evaluation of services.

(4) Organization:

(a) Each community mental health and developmental disability program shall have an up-to-date organizational chart showing the line of authority and responsibility from the local mental health authority to the community mental health and developmental disability program director and to each of the components of the community mental health and developmental disability program;

(b) Contracts:

(A) For all components of the community mental health and developmental disability program operated by agencies other than the local mental health authority, there shall be a contract between the local mental health authority and the service provider specifying the authorities and responsibilities of each party and conforming to the requirements of any Division rule or contract requirement pertaining to operation and delivery of services.

(B) In keeping with the principles of family support expressed in ORS 417.342, and notwithstanding ORS 430.670(2) or 291.047(3), an

entity operating a community mental health and developmental disability program may purchase services for an individual from a service provider without first providing an opportunity for competition among other service providers if the service provider is selected by the individual, the individual's family or the individual's guardian, as long as the service provider has been approved by the Division to provide such service.

(C) Limit on contract requirements. When a community mental health and developmental disability program contracts with a public agency or private corporation for delivery of developmental disability services, the community mental health and developmental disability program shall include in the contract only terms that are substantially similar to model contract terms established by the Division. The community mental health and developmental disability program may not add contractual requirements, including qualifications for contractor selection, that are nonessential to the service element(s) being provided under the contract. The community mental health and developmental disability program shall specify in contracts with service providers that disputes, which arise from these limitations, shall be resolved according to procedures contained in these rules. For purposes of this section, the following definitions apply:

(i) "Model contract terms established by the Division" means all applicable material terms and conditions of the omnibus contract, as modified to appropriately reflect a contractual relationship between the service provider and community mental health and developmental disability program, and any other requirements approved by the Division as local options under procedures established in these rules.

(ii) "Substantially similar to model contract terms" means that the terms developed by the community mental health and developmental disability program and the model contract terms require the service provider to engage in approximately the same type activitiy and expend approximately the same resources to achieve compliance.

(iii) "Nonessential to the service element(s) being provided" means requirements that are not substantially similar to model contract terms developed by the Division.

(D) Local Option. The community mental health and developmental disability program may, as a local option, impose on a public agency or private corporation delivering developmental disability services under a contract with the community mental health and developmental disability program, a requirement that is in addition to or different from requirements specified in the omnibus contract if all of the following conditions are met:

(i) The community mental health and developmental disability program has provided the affected contractors with the text of the proposed local option as it would appear in their contract, including the date upon which the local option would become effective, and a complete written description of how the local option would improve client independence, productivity, or integration into the community, or how it would improve protection of client health, safety, or rights;

(ii) The community mental health and developmental disability program has sought input from the affected contractors concerning ways the proposed local option will impact client services;

(iii) The community mental health and developmental disability program, with assistance from the affected contractors, has assessed the impact on the operations and financial status of the contractors if the local option is imposed;

(iv) The community mental health and developmental disability program has sent a written request for approval of the proposed local option to the Division's Assistant Administrator for Developmental Disability Services that includes:

(I) A copy of the information provided to the affected contractors;

(II) A copy of any written comments and a complete summary of oral comments received from the affected contractors concerning the impact of the proposed local option; and

(III) The text of the proposed local option as it would appear in contracts with service providers, including the proposed date upon which the requirement would become effective.

(v) The Division has notified the community mental health and developmental disability program that the new requirement is approved as a local option for that program; and

(vi) The community mental health and developmental disability program has advised the affected contractors of their right and afforded them an opportunity to request mediation as provided in these rules before the local option is imposed.

(E) Notice of Appeal.

(i) If a service provider believes that the contract offered by the community mental health and developmental disability program contains terms or conditions that are not substantially similar to those established by the Division in the model contract, the service provider may appeal imposition of the disputed terms or conditions by sending a written notice of appeal to the Division's Assistant Administrator for Developmental Disability Services within 30 calendar days after the effective date of the contract requirement. The notice of appeal shall include:

(I) A copy of the contract and any pertinent contract amendments;

(II) Identification of the specific term(s) that are in dispute; and

(III) A complete written explanation of the dissimilarity between terms.

(ii) The service provider shall send a copy of its notice of appeal to the community mental health and developmental disability program. Upon receipt of this notice, the community mental health and developmental disability program shall suspend enforcement of compliance with any contract requirement under appeal by the contractor until the appeal process is concluded.

(F) Appeal Process. The Assistant Administrator for Developmental Disability Services, or designee, shall offer to meet with both to mediate a solution. If a solution can not be mediated, the Assistant Administrator shall declare an impasse through written notification to all parties and immediately appoint a panel to consider arguments from both parties. The panel shall include, at a minimum, a representative from the Division's Office of Developmental Disability Services, a representative from another community mental health and developmental disability program, and a representative from another service provider organization. The panel shall meet with the parties, consider their respective arguments, and send written recommendations to the Administrator of the division within 45 business days after an impasse was declared. If an appeal requiring panel consideration has been received from more than one contractor, the Division may organize materials and discussion in any manner it deems necessary, including combining appeals from multiple contractors, to assist the panel in understanding the issues and operating efficiently. The Administrator shall notify all parties of his/her decision within 15 business days after receipt of the panel's recommendations. The decision of the Administrator is final. The community mental health and developmental disability program shall take immediate action to amend contracts as needed to comply with the Administrator's decision.

(G) Expedited Appeal Process. The community mental health and developmental disability program or the contractor may request an expedited appeal process that provides a temporary resolution, if it can be shown that the time needed to follow procedures to reach a final resolution would cause imminent risk of serious harm to individuals or organizations. The request shall be made in writing to the Division's Assistant Administrator for Developmental Disability Services. It shall describe the potential harm and level of risk that will be incurred by following the appeal process. The Division shall notify all parties of its decision to approve an expedited appeal process within two business days. If an expedited process is approved, the Administrator shall notify all parties of his/her decision concerning the dispute within three additional business days. The Administrator's decision resulting from an expedited appeal process shall be binding, but temporary, pending completion of the appeal process. All parties shall act according to the Administrator's temporary decision until notified of a final decision.

(H) Exception to limit on contract requirements for facilities. The community mental health and developmental disability program may add contract requirements that the community mental health and developmental disability program considers necessary to ensure the siting and maintenance of residential facilities in which client care is provided. These requirements shall be consistent with all applicable state and federal laws and regulations related to housing.

(5) Needs Assessment and Planning. The community mental health and developmental disability program shall assess local needs for services to persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, and shall plan for meeting those needs within the constraints of resources available. The local mental health authority shall review and approve the plan before it is submitted to the Division.

(6) Monitoring. The local mental health authority shall monitor all community mental health and developmental disability service elements to assure that:

(a) Service elements are provided as specified in the contract with the Division; and

(b) Service elements are in compliance with these rules and other applicable Division administrative rules.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5), (6), (9), (10) & (12), MHD 14-1982, f. & ef. 7-7-82; MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0025
Standards for Management of All Community Mental Health and Developmental Disability Program Areas

Each community mental health and developmental disability contractor providing a community mental health and developmental disability program area under a contract with the Division is required to meet the following standards for management:

(1) Organizations:

(a) Each community mental health and developmental disability program area contractor shall have an up-to-date organization chart showing the line of authority and responsibility from the local mental health authority to the community mental health and developmental disability program area director and to each of the components of the community mental health and developmental disability program area contractor;

(b) For all components of the community mental health and developmental disability program area contractor operated by agencies other than the local mental health authority, there shall be a contract between the local mental health authority and the subcontract agency specifying the authorities and responsibilities of each party and conforming to the requirements of any Division rule pertaining to contracts.

(2) Needs Assessment and Planning: When the Division contracts for a community mental health and developmental disability program area, the contractor shall assess local needs for services to persons within that program area, and shall plan to effectively and efficiently meet those needs within the constraints of available resources. The local mental health authority shall review and approve the plan before it is submitted to the Division.

(3) Monitoring: The local mental health authority shall monitor all community mental health and developmental disability service elements within the program area to assure that:

(a) Service elements are provided as specified in the contract with the Division; and

(b) Service elements are in compliance with these rules and other applicable Division administrative rules.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5) & (6), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0030
Standards for Management of All Service Elements

All contractors providing community mental health and developmental disability service elements under a contract with the Division are required to meet the following standards for management:

(1) Fee Policy. For all community mental health and developmental disability service elements, except local administration and those provided by a public education district, the agency providing the service element shall:

(a) Determine the cost of each type of service element provided;

(b) Establish a schedule of fees for service elements based on the costs of the service elements, adjusted on the basis of the client's ability to pay;

(c) At the time the service elements is initiated, inform the client of the agency fee policy, the agency fee schedules, and the fee rate to be collected from the client in the event that third party payments do not cover the cost of the client's service elements;

(d) Billings for Title XIX funds shall in no case exceed the customary charges to private clients for any like item or service charged by the service element; and

(e) Charge fees for service elements as follows:

(A) Except where expressly prohibited by federal law or regulation, when third party payments do not cover the full fee for the service elements provided, charge the client or those legally responsible for the cost of the client's care, in an amount which is the lesser of:

(i) The balance of the fee charged to but not paid by the third party payor(s); or

(ii) A fee adjusted on the basis of the client's ability to pay.

(B) Charge any third party payors in the amount of the full fees for the service elements provided. Should the sum of any third party payments and client payments exceed the fee, a refund of the excess payment shall be given to the client.

(2) Quality Assurance. Each provider of community mental health and developmental disability service elements shall implement and maintain a quality assurance program.

(3) Internal Management. Each provider of community mental health and developmental disability service elements funded by the Division shall meet the following internal management standards:

(a) There shall be an up-to-date organization chart showing lines of authority and responsibility for the services within the agency;

(b) There shall be up-to-date, written position descriptions for all staff providing community mental health and developmental disability services;

(c) If four or more staff provide community mental health and developmental disability services, there shall be written personnel policies and procedures concerning:

(A) Recruitment and termination of employees;

(B) Compensation plan;

(C) Performance appraisals, promotions and merit increases, and staff development;

(D) Employee benefits; and

(E) Grievance procedures.

(d) Each employee providing community mental health and developmental disability services shall have the opportunity for in-service training with pay;

(e) There shall be up-to-date accounting records for each mental health service element accurately reflecting all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities, consistent with generally accepted accounting principles and conforming to the requirements of OAR 309-013-0020;

(f) There shall be written statements of policy and procedure as are necessary and useful to assure compliance with any Division administrative rule pertaining to fraud and embezzlement and abuse of patients, residents, and clients; and

(g) There shall be such other written statements of policy and procedure as are necessary and useful to enable the agency to accomplish its mental health service objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(5) & (6), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0035
General Standards for Delivery of Community Mental Health and Developmental Disability Service Elements

All community mental health and developmental disability contractors providing community mental health and developmental disability service elements under a contract with the Division are required to meet the following general standards for delivery of community mental health and developmental disability service elements:

(1) Eligibility for Service:

(a) In accordance with the Civil Rights Act of 1964, community mental health and developmental disability services shall not be denied any person on the basis of race, color, creed, sex, national origin or duration of residence. Community mental health and developmental disability contractors shall also comply with Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR 84.4, which states in part, "No qualified person shall, on the basis of handicap, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance";

(b) No person shall be denied services or be discriminated against on the basis of age or diagnostic or disability category unless predetermined clinical or program criteria for service restrict the service to specific age or diagnostic groups or disability category;

(c) No person shall be denied community mental health and developmental disability services based on ability to pay;

(d) Any person eligible for community mental health and developmental disability services provided by one agency shall also be eligible for other community mental health and developmental disability services provided by any other agency, unless admission to the service is subject to diagnostic or disability category or age restrictions based on predetermined criteria.

(2) Continuity and Coordination:

(a) Each agency providing community mental health and developmental disability services shall make pertinent clinical and financial eligibility information concerning a client of the agency readily available to other community mental health and developmental disability service agencies responsible for the client's care, consistent with state statutes and federal laws and regulations concerning confidentiality;

(b) In the event that a person seeking or receiving services from one community mental health and developmental disability contractor requires services not provided by the contractor, the person shall be referred to an available appropriate agency which can provide the needed services;

(c) Planning and implementation of service for clients of the community mental health and developmental disability contractor shall be coordinated between components of the community mental health and developmental disability contractor, and other human service agencies, and between components of the community mental health and developmental disability contractor and state institutions. Each community mental health and developmental disability program or community mental health and developmental disability program area contractor shall maintain a written agreement with state institutions serving the county. The agreement shall include, but need not be limited to:

(A) The procedures to be followed to assure necessary communication between the state institution and the community mental health and developmental disability program or community mental health and developmental disability program area contractor when a client is admitted to, and discharged from, the state institution and during the period of care, treatment or training;

(B) The type of client information which will be shared by the community mental health and developmental disability program or community mental health developmental disability program area contractor and the state institution, the manner in which the information will be transmitted and the times when such information will be provided;

(C) The names of the staff members from the state institution and the community mental health and developmental disability program, or program area contractor, who will have principal responsibility for liaison and implementation of the agreement; and

(D) Each agreement between the state institution and a community mental health and developmental disability program, or program area contractor, shall be reviewed and renewed at least once a year.

(3) Service Records. A record shall be maintained for each client who receives direct treatment training and/or care services. The record shall contain client identification, problem assessment, treatment, training and/or care plan, medical information when appropriate; and progress notes.

(4) Retention of Records. Records shall be retained in accordance with OAR 166-005-0000 through 166-040-1050 (State Archivist). Financial records, supporting documents, statistical records, and all other records (except client records) shall be retained for a minimum of three years after the close of the contract period, or until audited. Client records shall be kept for a minimum of seven years.

(5) Confidentiality of Client Records. Client records shall be kept confidential in accordance with ORS 179.505, 45 CFR 205.50 and 42 CFR Part 2, any Division administrative rule pertaining to client records, and the most current edition of the Mental Health and Developmental Disability Services Division Handbook on Confidentiality.

(6) Client Rights. Each agency providing any community mental health and developmental disability service shall have written procedures to assure:

(a) Protection of client privacy and dignity;

(b) Confidentiality of records consistent with state statutes and federal statutes and regulations;

(c) Involvement of the client in planning the service through the provision of information, presented in general terms, which explains the following:

(A) The training or treatment to be undertaken;

(B) Alternative training or treatment methods available, if any; and

(C) Risks that may be involved in the training or treatment, if any.

(d) Client's right to refuse service unless otherwise ordered by a court; and

(e) Client is provided with information, presented in general terms, concerning the agency fee policies.

[Publication: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430

Stats. Implemented: ORS 430

Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(8) & (11), MHD 14-1982, f. & ef. 7-7-82 ; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0037
Dispute Resolution

(1) The community mental health and developmental disability program shall adopt a dispute resolution policy that pertains to disputes that may arise from contracts with service providers that deliver services funded by the Division for the community mental health and developmental disability program. Procedures implementing this policy shall be included in the contract with any such service provider.

(2) When a dispute exists between a county or a community mental health and developmental disability program and a service provider regarding the terms of their contract or the interpretation of an administrative rule of the Mental Health and Developmental disability Services Division relating to division programs under ORS Chapter 430, and local dispute resolution efforts have been unsuccessful, either party may request assistance from the Division in mediating the dispute.

(a) Procedure. The parties shall demonstrate a spirit of cooperation, mutual respect, and good faith in all aspects of the mediation process. Mediation shall be conducted as follows:

(A) Request. The party requesting mediation shall send a written request to the division administrator, the community mental health and developmental disability program director, and the provider agency director, unless other persons are named as official contact persons in the specific rule or contract under dispute. The request shall describe the nature of the dispute and identify the specific rule or contract provisions that are central to the dispute.

(B) Arrangements. The division administrator, or designee, shall arrange the first meeting of the parties at the earliest possible date. The agenda for the first meeting should include:

(i) Consideration of the need for services of an outside mediator. If such services are desired, agreement should be made on arrangements for obtaining these services.

(ii) Development of rules and procedures that will be followed by all parties during the mediation;

(iii) Agreement on a date by which mediation will be completed, unless extended by mutual agreement.

(C) Cost. Unless otherwise agreed to by all parties:

(i) Each party shall be responsible for the compensation and expenses of their own employees and representatives; and

(ii) Costs that benefit the group, such as services of a mediator, rental of meeting space, purchase of snack food and beverage, etc. shall be shared equally by all parties.

(b) Final Report. A written statement documenting the outcome of the mediation shall be prepared. This statement shall consist of a brief written statement signed by all parties or separate statements from each party declaring their position on the dispute at the conclusion of the mediation process. In the absence of written statements from other parties, the division representative shall prepare the final report. The final report on each mediation shall be retained on file at the division. The division will, from time to time, or as requested by the legislature or others, prepare summary reports that describe the success of mediation in resolving disputes.

Stat. Auth.: ORS 430

Stats. Implemented: ORS 430

Hist.: MHD 8-2000(Temp), f. 3-20-00, cert. ef. 3-21-00 thru 9-16-00; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

309-014-0040
Variances

A variance from these rules may be granted to a community mental health and developmental disability program in the following manner:

(1) An agency requesting a variance shall submit, in writing, through the community mental health and developmental disability program to the appropriate program or administrative office:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the local mental health authority indicating its support of the proposed variance.

(2) The assistant administrator of the program or administrative office shall approve or deny the request for variance.

(3) The program or administrative office shall notify the community mental health and developmental disability program of the decision. The community mental health and developmental disability program will forward the decision and reasons therefor to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the program or administrative office with a copy to other relevant sections of the Division.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division, whose decision shall be final.

(5) A variance granted by the Division shall be attached to, and become part, of the contract for that year.

Stat. Auth.: ORS 430
Stats. Implemented: ORS 430
Hist.: MHD 39, f. 5-20-76, ef. 6-11-76; Renumbered from 309-014-0000(13), MHD 14-1982, f. & ef. 7-7-82; MHD 13-2000, f. 9-15-00, cert. ef. 9-16-00

DIVISION 15

MEDICAID PAYMENT FOR PSYCHIATRIC HOSPITAL INPATIENT SERVICES

309-015-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe the eligibility criteria, methods, and standards for payments to psychiatric hospitals through the Office of Medical Assistance Programs, Oregon Department of Human Services. The rules apply to provision of psychiatric hospital inpatient services for persons eligible for medical assistance under Medicaid (Title XIX of the Social Security Act).

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 414.025, 414.065, and 414.085 and Title XIX of the Social Security Act and 42 CFR 441, Subparts C and D.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 12-1985(Temp), f. & ef. 7-1-85; MHD 7-1987, f. & ef. 12-30-87; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0005
Definitions

As used in these rules:

(1) "Active Treatment" means implementation of a professionally developed and supervised plan of care that is in effect within 14 days of admission and designed to achieve the patient's discharge at the earliest possible time. Custodial care is not active treatment.

(2) "Actual Costs" means all legitimate Medicaid expenditures. Since Oregon's Mental Health and Developmental Disability Services Division utilizes Medicare cost finding principles, actual costs will be the same as "Medicaid Allowable Costs" as defined in this rule.

(3) "Allowable Costs" means the costs applicable to the provision of psychiatric inpatient services as described in OAR 309-015-0050(3). They are derived using the Medicare cost finding principles located in the **Medicare Provide Reimbursement Manual**.

(4) "Annual Cost Report" means a financial report submitted to the Medicare/Medicaid Fiscal Intermediary by a hospital, on forms provided by the Fiscal Intermediary. This report details the actual revenues and expenses of the hospital during the latest fiscal period.

(5) "Base Year" means July 1, 1981 through June 30, 1982.

(6) "Disproportionate Share Adjusted Medicaid Rate" (DSR) means the weighted average Medicaid per diem rate (interim, year-end settlement or final settlement) for disproportionate share hospitals. This rate does not include the disproportionate share payment of uncompensated costs of participating hospital programs as provided in these rules.

(7) "Disproportionate Share Costs" means costs that are reimbursable under federal disproportionate share statutes and regulations. These costs are limited to costs of participating hospital programs which have not already been reimbursed by Medicare, Medicaid, insurance, or the patient's own resources.

(8) "Disproportionate Share Hospital" means a psychiatric hospital which has a low income utilization rate exceeding 25 percent as described in OAR 309-015-0035(5).

(9) "Disproportionate Share Payment" means the payment made quarterly to reimburse participating hospital programs for disproportionate share costs. This payment is subject to recalculation at the time of each year-end or final settlement payment.

(10) "Distinct Program" means a specialized inpatient psychiatric treatment program with unique admission standards approved by the Division. If a participating psychiatric hospital has a specialized program based upon patient age or medical condition, contains 50 or more beds, has a nursing staff specifically assigned to the program which has experience or training in working with the specialized population, and has record keeping systems adequate to separately account for expenditures and revenue to that program relative to the entire hospital, the Division may approve it as a distinct program.

(11) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(12) "Fiscal Intermediary" means:

(a) Blue Cross of Oregon for Medicare, Parts A and B; and

(b) Mental Health and Developmental Disability Services Division for Medicaid services provided under the provisions of this rule;

(c) The Assistant Administrator for Administrative Services, Mental Health and Developmental Disability Services Division, is the designated Fiscal Intermediary.

(13) "Inpatient Psychiatric Services" means active treatment services provided under the direction of a licensed physician by a participating psychiatric hospital.

(14) "Interim Per Diem Rate" means the daily rate established with and paid to each provider for the agreement period during which reimbursable services are to be provided.

(15) "Low Income Utilization Rate" means the sum of the ratio of a hospital's Medicaid revenues (plus governmental subsidies) to total revenue added to the ratio of a hospital's proportion of charity care expenditures (less governmental subsidies) to total inpatient psychiatric services charges (as outlined in OAR 309-015-0035(5)).

(16) "Maximum Allowable Rate" means the statewide average per diem cost for services as derived in accordance with OAR 309-015-0020 and 309-015-0021.

(17) "Medicaid" means Title XIX of the Social Security Act.

(18) "Medicaid Allowable Costs" means that portion of total costs determined to be eligible for Medicaid reimbursement. Medicaid allowable costs are determined based on the amount of allowable cost for inpatient services by making the following calculations:

(a) For all providers, determine the reasonable cost of covered services furnished by multiplying the ratio of Medicaid patient days to total patient days by total allowable inpatient costs;

(b) For proprietary providers, determine the allowable return on equity capital invested and used for the provision of patient care by following the general rule outlined in **42 CFR 413.157(b)**;

(c) Adding the results of the calculations in subsections (a) and (b) of this section to establish the full Medicaid allowable cost.

(19) "Medicaid Intermediary" for the purpose of services provided under this rule, means the Assistant Administrator for Administrative Services, Mental Health and Developmental Disability Services Division.

(20) "Medicaid Patient Days" means the accumulated total number of days, including therapeutic leave days, during which psychiatric inpatient services were provided to Medicaid eligible patients during a cost reporting period. The Fiscal Intermediary shall determine the total number of Medicaid patient days on the basis of dates of service per patient by provider and fiscal period.

(21) "Medicaid Inpatient Utilization Rate" means the following fraction (expressed as a percentage) for a hospital:

(a) "Numerator": The hospital's number of inpatient days attributable to patients who (for such days) were eligible for Title XIX medical assistance under the state Medicaid plan and for whom the

Office of Medical Assistance Programs made payment during the fiscal period;

(b) "Denominator": The total number of the hospital's inpatient days for the same period.

(22) "Medicare Market Basket Percentage Increase" means the annual allowable increase factor for a standard array of hospital services nationwide as published annually by the Health Care Financing Administration. The percentage is a component of the "Target Rate Percentage Increase" as defined in section (27) of this rule.

(23) "Non-Allowable Costs" means any costs excluded under the provisions of state and federal statutes, regulations, and administrative rules.

(24) "Participating Psychiatric Hospital"means those portions of a licensed psychiatric hospital certified to provide services to Medicaid patients.

(25) "Patient Eligibility" means persons eligible for medical assistance under Medicaid who meet the criteria for admission to psychiatric hospital inpatient services as defined in these rules and OAR 309-031-0200 through 309-031-0255.

(26) "Resident in the Hospital" means a patient who is in the facility at least 12 hours of each day, including the hours of sleep. The day of admission is exempt from this 12 hour rule; however, to be counted for residence purposes, the day of admission must extend through midnight (2,400 hours). The day of discharge is not counted.

(27) "Sanction" means:

(a) Termination of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients;

(b) Suspension of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients; or

(c) Suspension or withholding of payments to a provider. (See OAR 309-015-0052 for further information.)

(28) "Separate Cost Entity" means an entity of a hospital for which Medicare has approved the submission of a separate cost report.

(29) "Target Rate Percentage Increase" means the annual allowable increase factor applied to the previous year's maximum allowable rate for psychiatric hospitals and hospital units excluded from the prospective payment system. This percentage includes the Medicare market basket percentage increase as a component and is published annually by the Health Care Financing Administration.

(30) "Therapeutic Leave Days" means a planned and medically authorized period of absence from the hospital not exceeding 72 hours in seven consecutive days.

(31) "Total Patient Days" means the accumulated total number of days, excluding non-Medicaid therapeutic leave days, during which psychiatric inpatient services were provided to patients during a cost reporting period. The fiscal intermediary shall determine the total number of patient days on the basis of dates of service per patient by provider and fiscal period.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0007
General Conditions of Eligibility and Treatment

In order for payment to be made by the Division, the following conditions must be met:

(1) Medicaid-eligible age.The patient must be eligible for Medicaid benefits, be aged 65 or over, aged 20 or under, or aged 21 and receiving services at the time of reaching age 21.

(2) Written plan of care. A professionally developed written plan of care for each patient will describe treatment objectives and prescribe an integrated program of appropriate therapy activities and experiences designed to improve the patient's condition to the extent that inpatient care is no longer necessary.

(3) Unemancipated minor consultation. If the patient is under 18 years of age and not emancipated, the facility shall consult with the parent(s), legal guardian or others into whose care or custody the person will be released following discharge. The consultation shall be documented in the hospital records.

(4) Conformance with these rules. The Division has determined that admission and care of the patient who is eligible for Medicaid benefits is in accordance with these rules and regulations as evidenced by the hospital record.

(5) Service provider requirements. The service provider must meet all requirements for participation under OAR 309-015-0010.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0010
Conditions of Service Provider Participation

(1) Medicaid certification. A service provider must be certified by the responsible state or federal authority as meeting federal Medicaid certification requirements for psychiatric hospital inpatient services.

(2) Written agreement with the Division. A service provider must provide medically prescribed psychiatric hospital inpatient services to patients eligible for Medicaid benefits under terms of a written agreement with the Division. The agreement must assure that the psychiatric hospital and the services provided comply with all applicable state and federal requirements. No billing for Medicaid payment will be paid until a service provider has fully executed a written agreement with the Division.

(3) Legislative compliance. A service provider must be in compliance with:

(a) Title VI of the Civil Rights Act of 1964;

(b) Section 504 of the Rehabilitation Act of 1973;

(c) The Age Discrimination Act of 1975;

(d) The Americans with Disabilities Act of 1990; and

(e) Any other applicable federal and state laws.

(4) Medicaid vendor number. A service provider must request a vendor number from the Division. No billing for Medicaid payment will be paid until a service provider has secured a Medicaid vendor number.

(5) Patient admission. A service provider must obtain approval for the admission of patients to the psychiatric hospital as required by Mental Health and Developmental Disability Services Division Administrative Rules OAR 309-031-0200 through 309-031-0255 (Admission and Discharge of Mentally Ill Persons).

(6) Clinical records. A service provider must maintain clinical records which are adequate to document the need for psychiatric hospital inpatient services, and the specific services provided, including mental health assessment, diagnosis, and treatment plans.

(7) Fiscal records. A service provider must maintain fiscal records in accordance with generally accepted accounting principles.

(8) Patient funds. A service provider must provide an accounting for any funds accepted from the patient for safekeeping. Such accounts will be available for inspection by personnel designated by the Division.

(9) Records review. A service provider must maintain the availability of financial and treatment records for review without notice by authorized personnel of the Medicaid Intermediary and of the United States Department of Health and Human Services during normal business hours at the location of its licensed psychiatric hospital.

(10) Reimbursement for services. A service provider must accept payment from the Mental Health and Developmental Disability Services Division through the Office of Medical Assistance Programs as full and total reimbursement for the Medicaid services provided.

(11) Annual cost reports. A service provider must submit annually to the Division a Medicaid cost report accompanied by a copy of the provider's Medicare cost report.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90

309-015-0020
Establishing the Base Year and the Initial Maximum Allowable Rate

(1) Base year. In order to establish a base year rate, the Medicaid Intermediary used cost statements which overlapped the base period (July 1, 1981 through June 30, 1982) for all Oregon hospitals who were either:

(a) Licensed as psychiatric hospitals on the effective date of these rules (10-1-83) and in operation during the base period; or

(b) Were applicants for Joint Commission on Accreditation of Hospitals (JCAH) accreditation as a psychiatric hospital on the first effective date of these rules and had operated as a licensed hospital during the base period.

(2) Reporting period adjustments. If a psychiatric hospital's cost report was for a period either longer or shorter than 12 months, the Medicaid allowable costs were reduced or increased, as appropriate, by multiplying the total allowable costs by the ratio that 12 months bore to the number of months in the hospital's report period. This procedure resulted in a prorated 12-month cost projection for use in establishing the statewide average per diem rate for the base period.

(3) Inflation factor adjustments. If a psychiatric hospital had a fiscal period other than the base period, the hospital's Medicaid allowable costs were adjusted by applying the relevant inflation factors from the Medicare market basket index so that the Medicaid costs corresponded to the base period. The inflation factors were applied to the interval between the mid-point of the hospital's fiscal period and the mid-point of the base period. The number of Medicaid patient days in the hospital's fiscal period were used as the number of days in the base period.

(4) Rate calculation. The total Medicaid allowable costs from all hospitals included in the base period divided by the total number of Medicaid patient days from all hospitals included in the base period yielded the statewide average per diem cost (maximum allowable rate) for the base period.

Stat. Auth.: ORS 179, 414 & 430
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0021
Establishing the Maximum Allowable Rate for Years Following the Base Period

(1) Base rate usage. The statewide average per diem cost for the base period has been used as the fixed base for determining the maximum allowable reimbursement rate for all fiscal periods following the base period.

(2) Subsequent period rate calculations. The maximum allowable reimbursement rate for each new fiscal period affected by these rules is now calculated by inflating the maximum allowable reimbursement rate for the previous period by the annual Health Care Financing Administration target percentages for PPS — excluded hospitals (as published in the Federal Register). This percentage increase is applied from the mid-point of the previous period to the mid-point of the 12-month period for which the rate is being established.

(3) Hospitals with other fiscal periods. When a psychiatric hospital has a fiscal period other than that used by the State of Oregon, July 1 through June 30, the applicable maximum allowable rate for each month will be the same as the maximum allowable rate in effect that month for hospitals operating under the state fiscal period.

Stat. Auth.: ORS 179, 414 & 430
Stats. Implemented:
Hist.: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90

309-015-0023
Interim Rate Setting

Rate establishment process. At least annually, the Medicaid intermediary will establish an interim Medicaid per diem rate for each participating psychiatric hospital, separate cost entity or distinct program within a hospital:

(1) A hospital may request an interim per diem rate or rates. If a review of the hospital's prior year Medicaid cost report (adjusted for inflation, changes in patient populations and programs and other relevant factors) does not justify the requested rate(s), the Medicaid Intermediary may establish different interim rate(s):

(a) Actual expenditures for the most recent fiscal period available will be used to determine salary and wage and total expense distribution for each cost center included in the total expenditures. Any other directly relevant event, such as facility restructuring, will be considered as well;

(b) The Division will apply the proportions from subsection (a) of this section to total anticipated expenditures for the new period to determine salary and wage expense distribution for each cost center during the new period;

(c) The Division will establish and apply capital allowances and other adjustments to total anticipated expenditures for the new period from subsection (b) of this section;

(d) If the hospital has separate cost entities or distinct programs, the hospital will provide estimates to the Division of a weighted average interim rate. The average will be developed by multiplying each proposed interim rate by estimated Medicaid patient days for that rate, summing all of the products, and dividing that sum by the total annual estimated Medicaid patient days for the hospital;

(e) The interim or weighted average interim per diem rate may not exceed the maximum allowable rate unless the hospital meets the criteria for reimbursement above the maximum allowable rate as a disproportionate share hospital (see OAR 309-015-0035(5)). In that case, the interim or average interim Disproportionate Share adjusted Medicaid Rate (DSR) may include estimated costs up to 135 percent of the maximum allowable Medicaid rate except for hospitals meeting criteria set forth in the following paragraph;

(f) If a psychiatric hospital has a low-income rate of 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:

(A) Public funds, excluding Medicare and Medicaid;

(B) Bad debts; or

(C) Free care.

(g) The hospital qualifies to receive disproportionate share payment at a rate based on 100 percent of the costs of uncompensated care during the facility's previous fiscal year, subject to a disproportionate share allotment established for Oregon by the Health Care Financing Administration;

(h) The Division will base quarterly disproportionate share reimbursements on the estimated costs for each facility during the current fiscal year and will review and adjust the reimbursements, after conclusion of the fiscal period, to correspond with actual costs encountered during the period. Total reimbursement from disproportionate share and other sources will not exceed actual costs.

(2) If a hospital does not request an interim rate, the Medicaid Intermediary will establish an interim rate based on the hospital's prior year cost report using the same factors listed in section (1) of this rule.

Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 12-1985(Temp), f. & ef. 7-1-85; MHD 7-1987, f. & ef. 12-30-87, Renumbered from 309-015-0015; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0025
Retrospective Settlement Rate Setting (Year End and Final)

(1) Year-end settlement process. The year-end settlement process will be as follows:

(a) Upon receipt of an audited Medicaid cost report from the Supervisor of the Division Audit Section, the Revenue and Rates Manager of the Institutional Revenue Section will determine a retrospective year-end settlement rate for each participating hospital, separate cost entity or distinct program within a hospital on the basis of Division review of actual allowable Medicaid costs reported in the hospital's cost statement for the previous year;

(b) The year-end settlement rate for a non-disproportionate share hospital will be calculated by using the following procedure:

(A) Divide the applicable Title XIX allowable costs for each participating hospital, separate cost entity, or distinct program by the applicable number of Title XIX patient days, including therapeutic leave days;

(B) If the hospital has more than one distinct program, divide the applicable Medicaid allowable costs by the applicable number of Medicaid patient days, including therapeutic leave days for each program. Then determine the weighted average Medicaid settlement rate for the entire hospital. This is accomplished by multiplying each proposed year-end settlement rate by Medicaid patient days for that rate, adding the products together, and dividing the resulting sum by total Medicaid patient days for the hospital;

(C) If the year-end Medicaid settlement rate or the average year-end Medicaid settlement rate from above is less than the maximum allowable Medicaid rate for psychiatric hospitals during the current fiscal year, use the lower rate;

(D) If the year-end Medicaid settlement rate or the average year-end settlement rate from above exceeds the maximum allowable rate established for psychiatric hospitals during the current fiscal year, use the maximum allowable rate as the retrospective year-end settlement rate for the hospital.

(c) The year-end settlement rate may exceed the maximum allowable rate if the Division determines the hospital meets the criteria listed in OAR 309-015-0035(5) as a disproportionate share hospital;

(d) In that case, the disproportionate share adjusted year-end settlement rate will be calculated as follows:

(A) Actual costs up to 135 percent of the maximum allowable rate; or

(B) Actual costs up to 100 percent of the cost of uncompensated care during the facility's previous fiscal year, subject to a disproportionate share allotment established yearly by the Health Care Financing Administration, if the psychiatric hospital has a low-income rate of 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:

(i) Public funds, excluding Medicare and Medicaid;

(ii) Bad debts; or

(iii) Free care.

(e) The year-end settlement will be determined by multiplying the settlement "rate" calculated above by the total number of Medicaid patient days, including therapeutic leave days or, for disproportionate share hospitals, multiplying the disproportionate share adjusted rate by the total number of Medicaid patient days, including therapeutic leave days. The result will be compared to the amount of reimbursement paid to the hospital during the fiscal period. If the result favors the hospital, the Division will pay the difference to the hospital. If the result favors the Division, the hospital will pay the difference to the Division. In either case, payments shall be made within 30 days approval of the year-end Medicaid cost report by the Medicaid Intermediary.

(2) Final settlement process. The final settlement process will be as follows:

(a) Upon receipt of the final Medicare Cost Report from the Medicare Intermediary, the hospital provider will prepare the final Medicaid cost report. The Medicaid report will reflect all relevant adjustments made to the Medicare cost report;

(b) Using the final Medicaid cost report developed in subsection (a) of this section, the Division will calculate the final settlement rate and settlement for each participating hospital, separate cost entity or distinct program within a hospital, following the steps outlined in subsections (1)(a) through (d) of this rule.

(3) Upon completion of each settlement, both year-end and final, the Division will review the disproportionate share costs and make any necessary adjustments to quarterly disproportionate share payments. The Division will review all factors relevant to the disproportionate share payments, including actual costs of services, amounts already paid and charges reimbursed from other sources during the time period included in the Medicaid cost settlement.

Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0030
Billing Requirements

(1) Bill submission time limits. Bills shall be submitted to the Division through the Office of Medical Assistance Programs, on forms designated by the Medicaid Intermediary, as soon as possible after the date service is rendered. Payment shall not be made for services which were provided more than 12 months prior to presentation of the claim unless the hospital shows that the delay was caused by factors outside its control.

(2) Billing charge limits. Billings to the Division shall in no case exceed the customary charges to private patients for any like item or service charged by the hospital.

(3) Customary charge criteria. In determining the customary charges to a private patient for use in billings or calculating interim or settlement rates, the following criteria will be applied:

(a) The private patient billing rate must be for items and services comparable to the items and services included in the rate for Medicaid services;

(b) When private patient rates are based on the number of beds in a room, the Medicaid intermediary considers the lowest room charge as the usual and customary charge for services;

(c) When ancillary charges are made to private patients in addition to a basic charge, the Medicaid Intermediary considers the usual and customary charge to be the lowest basic room charge plus the average ancillary charge for those items included in the Medicaid rate. The average ancillary charge is determined by dividing the ancillary costs by the number of patient days; or

(d) Where charges are based on the classification of the patient (i.e., Medicare, Medicaid and Private), the Medicaid Intermediary considers the usual and customary charge to be the rate for private patients exclusive of ancillary charges.

(4) Payment restrictions. Payment will be made only for those days a patient is actually in residence at the hospital in active treatment or when a patient is on therapeutic leave.

(5) Payment credit. Any payment received by the hospital prior to the submission of an invoice to the Office of Medical Assistance Programs shall be indicated as a credit on the invoice.

(6) Post-payment receipt of funds. Any payments to the provider from any source subsequent to payment by the Office of Medical Assistance Programs shall be reported to that Division on an adjustment form specified by the Office of Medical Assistance Programs, giving full particulars. Failure to report such payments will be considered concealment of material facts and is grounds for recovery and/or sanction (see OAR 309-015-0052).

Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0035
Payments

(1) Timing. Payments to providers will be made following the month of service, based on the invoice submitted by the provider to the Office of Medical Assistance Programs.

(2) Eligible services. Payments will be made for the provision of active psychiatric inpatient treatment services for persons eligible for such services under Medicaid.

(3) Non-eligible services. If review of a psychiatric hospital's Medicaid patient records by a Professional Standards Review Organization reveals that a patient received an inappropriate level of care, (i.e., less than active treatment), payment will not be allowed under these rules. Any payments to the provider for patients receiving an inappropriate level of care shall be recovered by the Division. Such payments shall be reported to the Office of Medical Assistance Programs on an adjustment form specified by the Office of Medical Assistance Programs. Failure to report such payments will be considered concealment of material facts and is grounds for sanction (see OAR 309-015-0052).

(4) Payment to non-disproportionate share hospitals. The Division shall not pay more in total for psychiatric hospital inpatient services for hospitals which do not serve a disproportionate number of low-income patients with special needs than would be paid under the Medicare principles of reimbursement.

(5) Payment to disproportionate share hospitals. A participating psychiatric hospital may be reimbursed for allowable costs in excess of the maximum rate if it meets the following criteria as described in Section 1923(b)(3) of the Social Security Act: The hospital serves disproportionate numbers of low-income persons; i.e., has a low income utilization rate which exceeds 25 percent using the following formula:

(a) The total Medicaid in-patient revenues paid to the hospital, plus the amount of the cash subsidies received as payment for inpatient services directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient psychiatric services (including the amount of such cash subsidies) in the same cost reporting period. The percentage derived in paragraph (a) of this subsection shall be added to the following percentage;

(b) The total amount of the hospital's charges for in-patient psychiatric services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for inpatient services received directly from state and local governments described in paragraph (A) of this subsection in the period attributable to in-patient hospital services, divided by the total amount of the hospital's charges for in-patient psychiatric services in the hospital in the same period. The total in-patient charges attributed to charity care shall not include contractual allowances and discounts (other than for

indigent patients not eligible for Medical Assistance under an approved Medicaid State Plan);

(c) The sum of percentages derived in paragraphs (a) and (b) of this subsection shall exceed 25 percent in order to qualify as a disproportionate share hospital; and

(d) The hospital is efficiently and economically operated and is in compliance with treatment and program standards for psychiatric inpatient services as required by the state and federal statutes and regulations.

Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0040
Accounting and Record Keeping

(1) Records retention. The provider shall maintain, for a period of not less than three years following the date of submission of the annual Medicaid cost report to the Medicaid Intermediary, financial and statistical records of the period covered by such statement which are accurate and in sufficient detail to substantiate the cost data reported. If there are audit issues, the records shall be maintained for three years after the final audit settlement. The records shall be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules. Failure to maintain records in such condition shall result in disallowance of costs.

(2) Documentation of allowable costs. Expenses reported as allowable costs must be adequately documented in the financial records of the provider or they shall be disallowed.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0045
Filing of Annual Medicaid Cost Report

(1) Timing of report. The provider shall file annually with the Medicaid Intermediary, an annual Medicaid cost report covering actual costs based on the latest fiscal period of operation of the facility. If the provider has separate cost entities or distinct programs, an annual Medicaid cost report shall be filed for each entity. A Medicaid cost report will be filed for less than an annual period only when necessitated by facilities terminating their agreement with the Division, or by a change in ownership, or by a change in fiscal period. The provider is to use the same fiscal period for the Medicaid cost report as that used for the Medicare cost report and the federal tax return. The Medicaid cost report is due within 90 days of the end of the normal fiscal period, change of ownership, or withdrawal from the program except when Medicare grants an extension of the Medicare cost report (upon which the Medicaid cost report relies). In that case, the due date for the Medicaid cost report may be extended by the Medicaid Intermediary for the same number of days as the due date for the Medicare cost report.

(2) Contents of report. The annual Medicaid cost report is a uniform cost report containing an itemized list of allowable costs to be used by all providers. It shall report the hospital's actual financial data and be completed in accordance with instructions provided by the Medicaid intermediary.

(3) Application of Medicare principles of reimbursement. Providers filing annual Medicaid cost reports with the Medicaid Intermediary shall apply Medicare principles of reimbursement.

(4) Signature. Each required annual Medicaid cost report shall be signed by the individual who normally signs the provider's federal income tax return or other reports. If the report is prepared by someone other than an employee of the provider, the individual preparing the report shall also sign and indicate his or her status with the provider.

(5) Improperly completed reports. The Medicaid Intermediary shall return improperly completed or incomplete annual Medicaid cost reports to the provider for proper completion. All providers shall return corrected or completed reports to the Division within 30 days or become subject to the same penalty as for failure to submit the cost statement.

(6) Reduction of interim per diem rate — Late reports. If the original submission of the Medicaid cost report is not made within the required 90-day time period or extended period (see section (1) of this rule), the interim per diem rate then in effect will be reduced to 80 percent of the hospital's current interim per diem rate or the rate established from the last audited or desk reviewed cost statement, whichever is lower. This rate will remain in effect until submission of the Medicaid cost report.

(7) Late-billed services. If a hospital bills for services provided during a fiscal period for which the hospital has submitted an annual Medicaid cost report, the days which are late-billed may be included in the hospital's next fiscal period.

(8) False reports. If a provider knowingly, or with reason to know, files a report containing false information, such action constitutes cause for termination of its agreement with the Division. Providers filing false reports may be referred for prosecution under applicable statutes (see OAR 309-015-0052).

(9) Maintenance of report. The Medicaid Intermediary shall maintain each required annual Medicaid cost report submitted by a provider for three years following the date of submission. In the event there are audit questions, the cost statement shall be maintained for three years after the final audit settlement.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0050
Auditing

(1) Desk review of annual Medicaid cost report. The Medicaid intermediary will analyze by desk review each annual Medicaid cost report after it has been properly completed and filed.

(2) Scope of desk review. The scope of the desk review will verify, to the extent possible:

(a) That the provider has properly included its allowable costs on the annual Medicaid cost report on the basis of generally accepted accounting principles and the provisions of these rules;

(b) That the provider has properly applied the cost finding method specified by the Medicaid Intermediary to its allowable costs determined in subsection (a) of this section; and

(c) Whether or not the analysis indicates that further auditing of the provider's financial and statistical records is needed.

(3) Allowable costs. The costs considered allowable may include part or all of the following (worksheet form numbers are correct as of the effective date of this rule):

(a) The costs stated as final values on Worksheet B, HCFA-2552, Cost Allocation for General Services Costs;

(b) Physician costs as determined by completing Worksheet A-8-2, HCFA-2552;

(c) Return on equity as determined by completing the applicable portions of Worksheet F, HCFA-2552.

(4) Ownership changes. Payments to providers shall not be increased, solely as a result of a change of ownership, in excess of the increase which would result from applying Section 1861(v)(1)(O) of the Social Security Act as applied to owners of record on or after July 18, 1984.

(5) Field audit. All filed annual Medicaid cost reports are subject to a field audit.

(6) Scope of field audit. The scope of the field audit will, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to;

(b) Reported data is in agreement with supporting records; and

(c) The report is reconcilable to the appropriate Medicare report, federal tax return, and payroll tax reports.

[ED. NOTE: Worksheets referenced are available from the agency.]
Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 10-1984(Temp), f. & ef. 12-21-84; MHD 3-1985, f. & ef. 2-25-85; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0052
Provider Sanctions

(1) Bases for sanctioning. The Mental Health and Developmental Disability Services Division will follow the Office of Medical Assistance Program rules OAR 410-120-1400 through 410-120-1540 and

Section 1902 of the Social Security Act for provider sanctions. The bases for sanctioning will include:

(a) Criminal convictions;

(b) Exclusion, by the Secretary of Health and Human Services, from participation in the Medicare program;

(c) Not meeting the federal regulatory requirements for services in an institution for mental diseases or a psychiatric hospital as set forth at **42 CFR 435.1009** and **42 CFR 441**, **Subparts C** and **D**;

(d) Having deficiencies which immediately jeopardize, or may jeopardize, the health and safety of patients;

(e) Abuse and misutilization, as described in OAR 410-120-1440;

(f) Termination:

(A) From another governmental health/medical program;

(B) For failure to repay identified overpayments; or

(C) Due to commission, by a provider formerly suspended by the Mental Health and Developmental Disability Services Division, of additional abuse or misutilization.

(2) Sanctions. The following sanctions may be imposed on a provider by the Mental Health and Developmental Disability Services Division, based on grounds specified in this rule and may include:

(a) Termination from participation in Oregon's Medical Assistance Program and possible initiation of appropriate civil or criminal proceedings;

(b) Suspension from participation in Oregon's Medicaid Assistance Program;

(c) Suspension or withholding of payments to a provider;

(d) Required attendance at provider education sessions.

(3) Notice to providers. The Mental Health and Developmental Disability Services Division will notify a deficient provider of action the Division plans to take at least 15 days prior to commencement of the action; the notification will include an explanation of the provider's right to appeal the proposed action (see OAR 309-015-0055).

Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0055
Appeals

(1) Rate appeals. A letter will be sent notifying the provider of the interim per diem rate, the year-end settlement rate, or the final settlement rate. A provider shall notify the Division in writing within 15 days of receipt of the letter if the provider wishes to appeal the rate. Letters of appeal must be postmarked within the 15-day limit and addressed to the Assistant Administrator, Administrative Services (the Medicaid Intermediary).

(2) The Medicaid Intermediary will forward all rate appeals to the Manager of the Mental Health and Developmental Disability Services Division's Audit Section for initial consideration. If no resolution is forthcoming, the provider will be given an opportunity for administrative review or a contested case hearing as outlined in OAR 410-120-1560 through 410-120-1840, except that final orders shall be issued by the Administrator of the Mental Health and Developmental Disability Services Division.

(3) Monetary recovery, sanctions, or other appeals. A provider may appeal the Division's proposed action by letter within the same 15-day period as allowed for rate appeals above; address the letter to the Assistant Administrator, Administrative Services (the Medicaid Intermediary).

Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83; MHD 21-1983, f. & ef. 12-5-83; MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 12-1990, f. & cert. ef. 10-15-90; MHD 2-1994, f. & cert. ef. 2-24-94

309-015-0060
Emergency Services in Non-Participating Hospitals

Reimbursable services. Emergency services provided in licensed psychiatric hospitals not participating in Medicaid will be reimbursed if the Division determines they meet federal requirements for Medicare reimbursement of emergency services as outlined in **Subpart G**, **Part 424** of the Medicare regulations.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179.040 & 430.041
Stats. Implemented:
Hist.: MHD 7-1987, f. & ef. 12-30-87; MHD 6-1989, f. & cert. ef. 11-17-89; MHD 2-1994, f. & cert. ef. 2-24-94

DIVISION 16

MEDICAID PAYMENT FOR REHABILITATIVE MENTAL HEALTH SERVICES

309-016-0000
Purpose, Scope and Statutory Authority

(1) Purpose. These rules:

(a) Prescribe general standards for the provision of rehabilitative mental health Medicaid services to clients eligible for payment under Title XIX (Medicaid) of the **Social Security Act**, **Section 1905(a)(13) and Federal Regulations at 42 CFR 440.130(3)(d)**;

(b) Define procedures for billing the Mental Health and Developmental Disability Services Division (MHDDSD) for rehabilitative mental health services; and

(c) Outline the provider appeals and client complaint and appeals processes for rehabilitative mental health services delivered through MHDDSD or its subcontractors.

(2) Scope. These rules:

(a) Cover those Medicaid-eligible clients who:

(A) Receive rehabilitative mental health services in Extended Care Programs;

(B) Receive rehabilitative mental health services in an SOSCF Residential Program;

(C) Receive rehabilitative mental health services in an OYA Contracted Residential Program;

(D) Reside out-of-State in a subsidized adoption placement and maintain Oregon Medicaid coverage;

(E) Reside out-of-State in a foster care placement and maintain Oregon Medicaid coverage; or

(F) Who receive preauthorized out-of-state rehabilitative mental health treatment.

(b) Are applicable to rehabilitative mental health services provided by:

(A) Community Mental Health Programs (CMHPs);

(B) Extended Care Programs;

(C) SOSCF Residential Programs;

(D) OYA Contracted Residential Programs; and

(E) Non-Contiguous Area Providers.

(3) Statutory Authority. These rules are authorized by ORS 414.085, 430.041 and 430.640(1)(h) and carry out the provisions of ORS 430.021(2).

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0005
Definitions

As used in these rules:

(1) "Action" means a denial of Medicaid-covered services.

(2) "Adult and Family Services" or "AFS" means the Division of the Department of Human Services (DHS) with primary responsibility to assist eligible families in meeting their basic needs and to help them become more self sufficient.

(3) "Americans with Disabilities Act" or "ADA" means the Federal law promoting the civil rights of persons with disabilities, including mental illness. The ADA requires that reasonable accommodations be made in employment, service delivery and accessibility of facilities and/or services.

(4) "Amount" means the number and frequency of treatment sessions provided.

(5) "Biennial Plan" means a document submitted to MHDDSD by the Local Mental Health Authority (LMHA) in a format prescribed by MHDDSD each biennium.

(6) "Child" or "Children" means a person or persons under the age of 21.

(7) "Client" means a Medicaid-eligible individual with a mental or emotional disorder who requests or receives rehabilitative mental health services.

(8) "Client Process Monitoring System" or "CPMS" means the MHDDSD's client information system for community-based services.

(9) "Client Representative" means a person designated by a client as permitted in ORS 430.210(3) to assert and exercise the client's rights under ORS 430.210.

(10) "Clinical Record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services. The record is a collection of all documentation regarding a client's mental health treatment services. It is a legal document and provides the basis by which the provider manages service delivery and quality assurance. For the purpose of confidentiality, it is considered the medical record defined in ORS Chapter 179.

(11) "Clinical Supervision" means the documented oversight by a Clinical Supervisor of rehabilitative mental health treatment services provided by Qualified Mental Health Professionals (QMHPs) or Qualified Mental Health Associates (QMHAs) in accordance with OAR 309-016-0077.

(12) "Clinical Supervisor" means a designated QMHP with a Masters degree and at least two years post graduate clinical experience in a mental health treatment setting who subscribes to a professional code of ethics. The Clinical Supervisor, as documented by the Local Mental Health Authority (LMHA), operates within the scope of his or her practice and demonstrates the competency to oversee and evaluate the mental health treatment services provided by a QMHP or QMHA.

(13) "Community Mental Health Program" or "CMHP" means the organization of all services under ORS 430.630 for persons with mental or emotional disorders, drug abuse problems, mental retardation, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a Local Mental Health Authority (LMHA), and operated in a specific geographic area of the state under an omnibus contract with the MHDDSD.

(14) "Complaint" means an oral or written expression by the client or client representative of dissatisfaction to a Provider or MHDDSD.

(15) "Comprehensive Mental Health Assessment" means a mental status exam and a biopsychosocial evaluation of a client's functioning completed by a QMHP.

(16) "Consent to Treatment" means a written agreement between the client or the client representative and the Provider for the client to receive rehabilitative mental health services.

(17) "Corrective Action Plan" means a written document which specifies actions that a Provider will take to come into compliance with OAR 309-016-0000 through 309-016-0230.

(18) "Culturally Competent" means the capacity to provide services in an effective manner that is sensitive to the culture, race, ethnicity, language and other differences of an individual. Such services may include, but are not limited to, use of bilingual and bicultural staff, provision of services in culturally appropriate alternative settings, and use of bicultural paraprofessionals as intermediaries with professional staff.

(19) "Date of Action" means the intended date on which a denial of covered services becomes effective.

(20) "Declaration for Mental Health Treatment" means a written statement of a person's decisions concerning his or her mental health treatment. The declaration is made when the person, age 18 or older, is able to understand and make decisions related to such treatment. It is honored in the event the person becomes unable to make such decisions.

(21) "Direct Supervision" means the directing and coordinating by a QMHP of interventions performed by a QMHA. Direct supervision also means reviewing and evaluating the documentation of interventions by a QMHA. Direct supervision is performed on a regular, routine basis either individually or in a group setting.

(22) "Discharge Criteria" means the individualized standards to be met to complete service provision for each client.

(23) "Discharge Summary" means written documentation of the last service contact with the client, the diagnosis at enrollment, and a summary statement that describes the effectiveness of treatment modalities and progress (or lack of progress) toward treatment objectives while in service. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning, prognosis and recommendations for further treatment. Discharge summaries are completed within 30 calendar days after a planned discharge and within 45 calendar days after an unplanned discharge.

(24) "DSM Diagnosis" means the determination of a client's mental or emotional disorder as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The principal Axis I diagnosis provides the clinical basis for treatment, is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment and is entered on a written individualized Treatment Plan. Neither a DSM "V" code condition, substance use disorder or mental retardation may be considered the principal diagnosis, although these conditions or disorders may co-occur with the diagnosable mental disorder.

(25) "Duration" means the length of time used to provide:

(a) Specific treatment sessions; and

(b) An entire course of treatment.

(26) "Emergency" means the sudden onset of acute psychiatric symptoms requiring attention within 24 hours to prevent a serious deterioration in the client's mental status.

(27) "Enhanced Care Services" means an extended care program which consists of community-based health services, as defined in OAR 309-032-0720 through 309-032-0830, provided to eligible persons who reside at facilities licensed by the Senior and Disabled Services Division. Placement in the projects is approved by the Enhanced Care Services Coordinator of the Office of Mental Health Services.

(28) "Enhanced Care Services Coordinator" means an employee of the Office of Mental Health Services, Mental Health and Development Disability Services Division, responsible for managing utilization of the enhanced care services projects of the Extended Care Program. The Coordinator provides clinical assessment and placement of older adults and younger disabled adults with severe and persistent mental illness who require long-term structure, support, rehabilitation and supervision within the enhanced care services projects. The Coordinator also provides monitoring, oversight and technical assistance to the enhanced care programs.

(29) "Enrollment" means:

(a) The entry of a Medicaid-eligible client into rehabilitative mental health services. This entry is documented by a completed CPMS enrollment form or, in case of a Medicaid-eligible child residing out-of-state, by the written authorization of MHDDSD; or

(b) The approval of a Provider as a provider of rehabilitative mental health services under this rule. Approval is documented by the issuance of a Certificate of Approval and enrollment with MHDDSD or enrollment in the Oregon Medical Assistance Program.

(30) "Extended Care Management Unit" or "ECMU" means the unit within the Office of Mental Health Services, Mental Health and Developmental Disability Services Division, responsible for maintaining State Hospital and local acute inpatient census within or below budgeted capacity and managing the utilization of extended care projects. The unit provides the clinical assessment and placement of adults with severe and persistent mental illness who require long term structure, support, rehabilitation and supervision within designated projects of the Extended Care Program.

(31) "Extended Care Program" means a state-funded program designed to provide necessary services in a least restrictive environment, utilizing a range of hospital, residential and community resources. These programs include secure residential facilities, residential psychiatric treatment, Child and Adolescent Treatment Services at Oregon State Hospital, Treatment Foster Care, Therapeutic Group Home, Geropsychiatric Treatment Program at Oregon State Hospital, Senior and Disabled Services Division enhanced care and PASSAGES projects.

(32) "Fee-For-Service" or "FFS" means the payment made for each reimbursable service retrospectively based upon cost of providing the service.

(33) "Goal" means an expected result or condition to be achieved, which is specified in a statement of relatively broad scope, provides a guideline for the direction of care and is related to an identified clinical problem as stated on the Treatment Plan.

(34) "Hearing" means:

(a) For clients, an administrative hearing related to a denial of benefits which is held when requested by a client or client representative. A hearing may also be held when requested by a client or client representative who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously; or

(b) For providers, an administrative hearing regarding appeal of:

(A) A denial of or limitation of payment allowed for services or items provided;

(B) Sanctions imposed, or intended to be imposed, by MHDDSD; or

(C) Overpayment determinations.

(35) "Level of Care" means the range of available mental health services provided from the least restrictive and least intensive in a community-based setting to the most restrictive and most intensive in an inpatient setting. As required in ORS 430.210(a), clients are to be served in the most normative, least restrictive, least intrusive level of care appropriate to their treatment history, degree of impairment, legal status, current symptoms and the extent of family or other supports.

(36) "Licensed Medical Practitioner" or "LMP" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon; or

(C) Physician's Assistant licensed to practice in the State of Oregon.

(b) Whose training, experience and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(37) "Local Mental Health Authority" or "LMHA" means the county court or board of county commissioners of one or more counties who choose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation which contracts with MHDDSD to operate a CMHP for that county.

(38) "Medicaid Authorization Specialist" or "MAS" means a Qualified Mental Health Professional designated at the county or regional level to determine the rehabilitative mental health needs of children requiring services in an SOSCF or OYA Contracted Residential Program and to authorize the provision of rehabilitative mental health services identified in the Service Authorization Form (SAF).

(39) "Medical Supervision" means an LMP's determination, at least annually and at intervals prescribed by the Office of Mental Health Services (OMHS), of the medical appropriateness of rehabilitative mental health services for each client in accordance with OAR 309-016-0075.

(40) "Medically Appropriate" means the determination by an LMP, operating within the scope of his or her license, training and experience, that a service is required for prevention (including preventing a relapse), diagnosis or treatment of mental health conditions and is appropriate and consistent with the diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental condition; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the client or provider of the service; and the most cost-effective of the alternative levels of medically appropriate services which can be safely and effectively provided to the client.

(41) "Medication Service Record" means the documentation of written or verbal orders for medication, laboratory, and other medical procedures issued by an LMP employed by, or under contract with, the provider and acting within the scope of his or her license. The provision of medical services is documented in written progress notes and placed in the clinical record.

(42) "Mental Health and Developmental Disability Services Division" or "MHDDSD" means the Department of Human Services (DHS) Agency responsible for the administration of State mental health and developmental disability services to persons who qualify for certain programs under federal and state laws, rules and regulations.

(43) "Mental Health Assessment" means determination by a QMHP during the enrollment process and periodically thereafter as clinically appropriate of the client's need for rehabilitative mental health services. It involves collection and assessment of data pertinent to the client's mental health history and current mental health status obtained through interviews, observation, testing, and review of previous treatment records. The activities conclude with:

(a) A determination of a DSM Axis I diagnosis, which provides the clinical basis for treatment and is entered on a written Treatment Plan; and

(b) A determination and justification of the client's priority for service, under OAR 309-016-0100 or 309-016-0102, which is entered in the clinical record; or

(c) A written statement, supported by assessment and interview data, which indicates that the person is not in need of rehabilitative mental health services. Other disposition information such as to whom the person was referred and the date the Notice of Denial was given or sent shall be included in the statement.

(44) "MHDDSD Representative" means the person having the authority to represent MHDDSD under the current Administrative Procedures Act. Responsibilities of the MHDDSD Representative include, but are not limited to the following:

(a) Collecting information from sources;

(b) Documenting findings and conclusions;

(c) Identifying, scheduling, interviewing and calling witnesses;

(d) Testifying on behalf of MHDDSD; and

(e) Cross-examining witnesses testifying during the hearing.

(45) "Non-Contiguous Area Provider" means a provider located more than 75 miles from Oregon and enrolled with MHDDSD.

(46) "Notice of Denial" means the notice given or sent to the client upon denial, termination, suspension or reduction of services which explains the clients right to appeal such a decision and the process to appeal such a decision.

(47) "Objective" means the written statement of an expected result or condition that is related to the attainment of a goal. The objective is stated in measurable terms and has a specified time for accomplishment.

(48) "Office of Medical Assistance Programs" or "OMAP" means the Office of the Oregon Department of Human Services responsible for coordinating the Medical Assistance Program within the State of Oregon.

(49) "Office of Mental Health Services" or "OMHS" means the program office of MHDDSD responsible for the administration of mental health services for the State of Oregon.

(50) "OMB Circular A-122" means the Circular established by the Federal Office of Management and Budget which sets forth the principles for determining costs of grants, contracts and other agreements.

(51) "Oregon Youth Authority" or "OYA" means the Department created by the 1995 Legislative Assembly that has responsibility for care and housing of child and adolescent offenders adjudicated and sentenced by juvenile justice to the juvenile correction system.

(52) "OYA Contracted Residential Program" means an organization which has written approval from MHDDSD to provide rehabilitative mental health treatment for children aged three through 20 licensed by, and contracted with, OYA to provide residential services to children in the custody of OYA.

(53) "PASSAGES Projects" means one type of extended care program which consists of community-based services for adults with severe and persistent mental illness who have been hospitalized for over six months in a state hospital or who have had difficulty maintaining stability in other structured community settings. Placements in these projects are approved by the Extended Care Management Unit of the Office of Mental Health Services.

(54) "Performing Provider" means a Non-Contiguous Area Provider, CMHP or public or private community agency or organization under contract with a CMHP that directly provides rehabilitative mental health services as described by OAR 309-016-0000 through 309-016-0230 (SOSCF and OYA Contracted Residential Programs are included in this definition).

(55) "Progress" means the movement toward the individual treatment goal(s) using measurement criteria in the client's Treatment Plan set by the provider and, if exercised under ORS 430.210(3), the client, the client representative and/or any representative designated by the client.

(56) "Progress Note" means the written documentation of the clinical course of treatment which becomes the basis for review and revision of the Treatment Plan and the clinical course of treatment. Each progress note shall contain the documentation required by the 309-016-0080(4), Clinical Records Requirements.

(57) "Provider" means a CMHP, Performing Provider, and/or Non-Contiguous Area Provider.

(58) "Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee:

(a) A bachelor's degree in a behavioral sciences field; or

(b) A combination of at least three year's relevant work, education, training or experience; and

(c) Has the competencies necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and

(C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

(59) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

(a) Graduate degree in psychology;

(b) Bachelor's degree in nursing and licensed by the State of Oregon;

(c) Graduate degree in social work;

(d) Graduate degree in a behavioral science field;

(e) Graduate degree in recreational, art, or music therapy; or

(f) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(g) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family, and/or group therapy within the scope of his or her practice.

(60) "Quality Assurance" or "QA" means the structured, internal monitoring, and evaluation process to:

(a) Identify aspects of quality care;

(b) Use indicators and clinical criteria to continually and systematically monitor these aspects of care;

(c) Establish markers which indicate problems or opportunities to improve care;

(d) Take action to correct problems and improve substandard care;

(e) Assess the effectiveness of the actions; and

(f) Document the improvements in care.

(61) "Quality Assurance/Quality Improvement Plan" or "QA/QI Plan" means a plan which describes the provider's Quality Assurance and Quality Improvement process.

(62) "Quality Improvement" or "QI" means a management technique used to establish and revise as necessary services, standards and goals directed at improving the overall quality of the services.

(63) "Rehabilitative Mental Health Services" means those FFS services listed in the MHDDSD Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule. The QMHP or QMHA must provide these FFS services upon the recommendation or under the supervision of an LMP as prescribed by 309-016-0075. SOSCF or OYA Contracted Residential Program services are also considered to be rehabilitative services under these rules. These services must be provided by either a:

(a) Licensed Medical Practitioner (LMP);

(b) Qualified Mental Health Professional (QMHP) under clinical supervision of a clinical supervisor; or

(c) Qualified Mental Health Associate (QMHA) under the direct supervision of a QMHP and under clinical supervision of a clinical supervisor.

(64) "Sanction" means an action against a provider taken by MHDDSD in cases of non-compliance, fraud, misuse or abuse of Medicaid.

(65) "Scope" means the extent or range of the type of rehabilitative mental health services provided.

(66) "Service Authorization Form" means a written, individualized record of authorized rehabilitative mental health treatment services developed by the Provider for select children who receive such services in an SOSCF or OYA Contracted Residential Program.

(67) "Setting" means the locations at which mental health treatment services are provided. Settings include such locations as mental health offices, an individual's home or school or other identified locations.

(68) "State Office for Services to Children and Families Residential Programs" or "SOSCF Residential Program" means an organization which has written approval from MHDDSD to provide mental health treatment for children aged three through 20 licensed by, and contracted with, SOSCF to provide residential services to children in the custody of SOSCF.

(69) "Therapeutic Group Home" means the planned treatment of a child using theoretically based individual and group skills development and medication management, individual therapy and consultation as needed to remediate significant impairments in the child's functioning that are the result of a principal mental or emotional disorder diagnosed on Axis I of a completed DSM 5-axes diagnosis.

(70) "Treatment" means a planned, medically appropriate, individualized program of interactive medical, psychological, rehabilitative procedures, therapeutic interventions, experiences, and/or activities designed to rehabilitate, relieve or minimize mental or emotional disorders identified through a mental health assessment and provided by a QMHP or QMHA.

(71) "Treatment Foster Care" means a program of rehabilitative mental health services prescribed in a child's Treatment Plan provided in the child's foster home.

(72) "Treatment Plan" means a written individualized program of treatment goals, measurable objectives and services to be provided. A QMHP and, if they elect to do so under ORS 430.210(3) the client and/or client representative, will develop the Treatment Plan which includes the amount, duration and scope of services. The Treatment Plan will be revised and the LMP will approve the plan at least annually.

(73) "Urgent" means the onset of psychiatric symptoms requiring attention within 48 hours to prevent a serious deterioration in a client's mental health condition.

(74) "Utilization Review" means a retrospective process through which a random sample of cases are reviewed at periodic intervals established by the provider, to safeguard against unnecessary or inappropriate use of rehabilitative mental health services.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h).
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 2-1993(Temp), f. 5-27-93, cert. ef. 6-1-93; MHD 4-1993, f. & cert. ef. 11-30-93; MHD 3-1994(Temp), f. & cert. ef. 4-15-94; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0010
Conditions of Provider Participation — General

All Providers participating in rehabilitative mental health services shall be contractually affiliated with the LMHA, the CMHP or, in the case of a Non-Contiguous Area Provider, directly with MHDDSD or employed by the LMHA and enrolled as a Performing Provider.

(1) All providers shall abide by applicable portions of:

(a) These rules, OAR 309-016-0000 through 309-016-0230;

(b) The Office of Mental Health Services (OMHS) Rules; and

(c) The General Rules for the Oregon Medical Assistance Programs, OAR 410-120-0000 through 410-120-1980.

(2) MHDDSD will contract with CMHPs to provide rehabilitative mental health services to Medicaid-eligible clients on a fee-for-service basis.

(3) The CMHP must:

(a) Have a signed written contract with MHDDSD and a Certificate of Approval prior to delivering services; and

(b) Provide the treatment directly or through written subcontract.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h).
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 4-1993, f. & cert. ef. 11-30-93; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0015
Qualifications for Community Mental Health Programs (CMHPs)

(1) To qualify for approval and enrollment as a Provider of rehabilitative mental health services under this rule, a CMHP must provide

directly, or through written subcontract, the following services as defined in applicable Office of mental Health Services program rules and as governed by OAR 309-016-0000 through 309-016-0230:

(a) Adult mental health services in accordance with OAR 309-032-0525 through 309-032-0605 and 309-032-0720 through 309-032-0830; and

(b) Children's mental health services in accordance with OAR 309-032-0950 through 309-032-1080;

(c) Adult Foster Home Services as defined in OAR 309-040-0000 through 309-040-0100; or

(d) Residential Facility Services as defined in OAR 309-035-0100 through 309-035-0190.

(2) The prospective CMHP must:

(a) Apply to the MHDDSD Title XIX Section for approval and enrollment as a Provider of rehabilitative mental health services in a format prescribed by MHDDSD;

(b) Hold a valid Certificate of Approval granted by MHDDSD for each type of service provided; and

(c) Enroll in the Oregon Medical Assistance Program based upon written application to MHDDSD and determination by MHDDSD, which substantiates compliance with the requirements of OAR 309-016-0010. Prospective CMHPs will be notified of their enrollment or denial of their application in writing.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1993, f. & cert. ef. 11-30-93; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0020
Administrative Requirements for Community Mental Health Programs (CMHPs)

CMHPs shall meet the following requirements:

(1) Have a full-time program director meeting the following minimum requirements:

(a) A Master's degree in a behavioral, social or health science, special education, public administration, or human service administration field; and

(b) A minimum of five years of experience in human services programs, at least two of which are in community rehabilitative mental health.

(2) Have an advisory committee which shall:

(a) Meet at least quarterly;

(b) Have membership reflective of the geographic area, including appropriate cultural and ethnic representation as defined by the CMHP. This membership shall include:

(A) Consumers of mental health services and their families;

(B) Advocates for persons with mental or emotional disorders; and

(C) Persons with interest or experience in developing programs specific to mental health service needs.

(c) Advise and assist in the review, monitoring and evaluation of services and in the development and implementation of recommendations for the improvement of services.

(3) Have written contracts with all subcontractors specifying the authorities and responsibilities of each party and conforming to the requirements of all applicable MHDDSD rules and provisions of the agreement between MHDDSD and the CMHP.

(4) Review and monitor services, including those provided by Performing Providers, to assure:

(a) Provision of services as specified in the contract with MHDDSD;

(b) Consistency with the Office of Mental Health Services administrative rules and other applicable MHDDSD administrative rules. The CMHP shall:

(A) Report to MHDDSD any areas of substantial noncompliance;

(B) Provide MHDDSD with a Corrective Action Plan for revision, at its discretion, and approval; and

(C) Provide on-going evaluation and training that supports continued affiliation with Performing Providers.

(c) Coordination of services delivered to each client by more than one Performing Provider;

(d) Documentation of LMP, Clinical Supervisor, QMHP and QMHA qualifications; and

(e) Documentation of clinical supervision and direct supervision.

(5) Provide services in accordance with the Civil Rights Act of 1964, the Americans with Disabilities Act and any other state and federal laws and regulations listed in the contract with MHDDSD.

(6) Coordinate service planning and implementation with any organization involved with a client in any of the following treatment domains:

(a) Cognitive;
(b) Family;
(c) Substance abuse;
(d) Emotional;
(e) Behavioral;
(f) Developmental;
(g) Social;
(h) Physical health/medical care;
(i) Nutritional;
(j) School or vocational;
(k) Cultural; and
(l) Legal.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0027
CMHP Medicaid Authorization Specialist Responsibilities for Medicaid-Eligible Children

Each CMHP shall provide the services of a Medicaid Authorization Specialist (MAS). The MAS will:

(1) Assure that referrals to SOSCF or OYA Contracted Residential Programs are made in accordance with OAR 309-016-0130.

(2) Perform administrative functions, in accordance with OAR 309-016-0000 through 309-016-0230, necessary to:

(a) Monitor service utilization patterns;

(b) Collect data and maintain required program records; and

(c) Authorize the amount, duration and scope of rehabilitative mental health services in SOSCF or OYA Contracted Residential Programs in accordance with OAR 309-016-0130.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 4-1991, f. & cert. ef. 7-29-91; MHD 2-1993(Temp), f. 5-27-93, cert. ef. 6-1-93; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 3-1994(Temp), f. & cert. ef. 4-15-94; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0030
Record Retention Requirements for Providers

All Providers shall retain complete and legible financial and clinical records in accordance with OAR 166-005-0000 through 166-040-1050 (State Archivist). Financial records shall be retained for a minimum of three years and clinical records shall be retained for a minimum of seven years. If an audit, litigation, research and evaluation, or other action involving the financial or clinical record is started before the end of the established retention period, the financial or clinical record must be retained until all issues arising out of the action are resolved or until the end of the established retention period, whichever is later.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0035
Client Rights

All Providers must ensure provision of the client rights in ORS 430.210 and have written procedures to assure client rights listed below. Providers shall visibly post these rights in an area frequented by clients and shall explain them both orally and in writing to the client or person giving legal consent to treatment and obtain his or her signature. If the client or client representative refuses to or is unable to sign, the Provider will document this in the client record. Client rights include, but are not limited to, the following:

(1) Protection of client confidentiality, privacy, and dignity;

(2) Interactive involvement of the client or client representative in treatment planning including, but not limited to, the provision of information. Providers must present this information in a language and

style that is easily understood with the offer to answer questions and an explanation of the following:

(a) The treatment to be undertaken;

(b) Alternative treatment methods available, if any;

(c) Benefits reasonably to be expected; and

(d) Risks that may be involved in the treatment, if any.

(3) Consent to and refusal of services unless otherwise ordered by a court or permitted by State statute as defined in OAR 309-032-1030, Childrens Rights and OAR 309-032-0555, Consumer Rights Specific to Services Rendered;

(4) Explanation of, and access to, the complaint and hearings process for resolving oral or written expressions of disagreement or dissatisfaction with the provider or for resolving decisions concerning a denial, termination, suspension, or reduction of services;

(5) Access to records; and

(6) If desired by the client, age 18 or older, the development of a Declaration for Mental Health Treatment and assistance in making such a declaration.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0040
Provider Sanctions

Sanction for Non-Compliance with OAR 309-016-0000 through 309-016-0230:

(1) If a Provider does not maintain compliance with applicable requirements in 309-016-0000 through 309-016-0230, the CMHP shall notify MHDDSD and submit a written Corrective Action Plan to MHDDSD for approval within 10 days of its first knowledge of non-compliance. The Corrective Action Plan shall include:

(a) Identification of all areas of non-compliance;

(b) Description of specific activities to be undertaken to achieve compliance;

(c) A completion date for each activity and the date by which full compliance will be achieved;

(d) Identification of persons responsible for completing each activity; and

(e) In the case of Performing Provider non-compliance, a schedule for monitoring by the CMHP to assure on-going compliance. Performing Providers have responsibility to report non-compliance to their CMHP within 10 days of its first knowledge of non-compliance.

(2) MHDDSD shall review and monitor Corrective Action Plans and approve, in writing, those plans which, in the opinion of MHDDSD, have a probability of success. Prior to approval, MHDDSD may choose to:

(a) Revise or modify the Corrective Action Plan;

(b) Require the Provider to obtain technical assistance or consultants; and/or

(c) Conduct an on-site review of the Provider.

(3) MHDDSD shall deny approval, in writing, of those Corrective Action Plans that are, in the opinion of MHDDSD, incomplete or do not have a probability of success.

(4) If a Corrective Action Plan is not approved by MHDDSD, or, if the Provider is unable to meet the requirements of an approved Corrective Action Plan, MHDDSD may terminate enrollment of the Provider in the Oregon Medical Assistance Program. MHDDSD may impose further sanctions as allowed under General Rules for the Oregon Medical Assistance Program.

(5) If the CMHP does not inform MHDDSD of non-compliance within the specified time period, MHDDSD may terminate the enrollment of the Provider in the Oregon Medical Assistance Program retroactive to the date of non-compliance and may impose further sanctions as allowed under General Rules for the Oregon Medical Assistance Program.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0070
Performing Provider Requirements

(1) Performing Providers (except for Non-Contiguous Area Providers) shall be in receipt of or included in a Certificate of Approval granted under OAR 309-012-0130 through 309-012-0220 for the rehabilitative mental health services to be delivered.

(2) Performing Providers shall deliver all services under medical supervision in a manner which complies with OAR 309-016-0075, and clinical supervision in a manner which complies with OAR 309-016-0077 and applicable Office of Mental Health Services program rules.

(3) Agencies that seek to become Performing Providers shall apply to the MHDDSD Title XIX Section to be enrolled as a vendor in the Oregon Medical Assistance Program. Only services provided after the date the Performing Provider has been enrolled and issued a vendor number may be billed.

(4) Performing Providers may only provide services if they are operating under subcontract with a CMHP or enrolled with MHDDSD, in the case of Non-Contiguous Area Providers. Performing Providers operating under subcontract shall request a Medicaid vendor number from the MHDDSD Title XIX Section through the CMHP. Only services provided after the date the Performing Provider has been issued a vendor number may be billed.

(5) Performing Providers shall determine if any enrolled client is also receiving rehabilitative mental health services from any other Medicaid Provider of mental health services covered by OAR 309-016-0000 through 309-016-0230, and routinely report this information to the CMHP on a schedule determined by the CMHP.

(6) Performing Providers, including SOSCF or OYA Contracted Residential Programs, shall report to the CMHP in writing, on a schedule to be determined by the CMHP but at least every three months, the case name; the amount, duration and scope of rehabilitative mental health services authorized on the Service Authorization Form by the MAS, the dates of the authorization and any other data required by MHDDSD to be collected.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 3-1994(Temp), f. & cert. ef. 4-15-94; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0072
Conditions of Non-Contiguous Area Provider Participation

All Non-Contiguous Area Providers participating in rehabilitative mental health services must be enrolled as Performing Providers and are subject to the applicable Provider standards stated in these rules.

(1) MHDDSD will enroll Non-Contiguous Area Providers for the provision of prior-authorized rehabilitative mental health services to specific Oregon Medicaid-eligible clients who:

(a) Reside out-of-state in a subsidized adoption;

(b) Reside out-of-state in a foster care placement; or

(c) Reside in the State of Oregon but require specialized treatment, as defined by MHDDSD, which is not available in the State of Oregon and/or provision of the treatment by a Non-Contiguous Area Provider is determined by MHDDSD to be cost-effective.

(2) Non-Contiguous Area Providers must be enrolled with MHDDSD prior to delivering services, unless the service is urgent or emergent or a delay could be expected to result in prolonged impairment or increase the risk that treatment will become more complex or hazardous. In such cases, the Non-Contiguous Area Provider must make every reasonable effort to contact MHDDSD Title XIX Section within three working days and document such effort.

(3) Non-Contiguous Area Providers shall abide by relevant portions of these rules, OAR 309-016-0000 through 309-016-0230, applicable Office of Mental Health Services rules and the General Rules for Oregon Medical Assistance Programs, OAR 410-120-0000 through 410-120-1980.

(4) All services must be provided directly by a Non-Contiguous Area Provider under:

(a) Medical supervision in accordance with 309-016-0075 by an LMP operating within the scope of his or her license in the state of licensure; and

(b) Clinical supervision in accordance with 309-016-0077 by a Clinical Supervisor operating within the scope of his or her practice.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0075
Medical Supervision

All Providers shall deliver services under medical supervision in accordance with 309-016-0000 through 309-016-0230 and the Office of Mental Health Services (OMHS) rules. Medical supervision shall be secured through a current written agreement, job description, or similar type of binding arrangement between a Licensed Medical Practitioner (LMP) and the Provider which describes an LMP's responsibility in determining the medical appropriateness of rehabilitative mental health services. The LMP must perform medical supervision at least annually by reviewing the Comprehensive Mental Health Assessment and approving the revised Treatment Plan. Providers will utilize the LMP within the individual's scope of practice. Psychiatrists will be involved when medically appropriate and each program shall assure access to psychiatric services.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 3-1994(Temp), f. & cert. ef. 4-15-94; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0077
Clinical Supervision

All Providers shall deliver medically appropriate services under clinical supervision in accordance with OAR 309-016-0000 through 309-016-0230 and applicable Office of Mental Health Services rules. Clinical supervision includes evaluating the effectiveness of the mental health treatment services provided. Clinical Supervision shall be secured through a current written agreement, job description, or similar type of binding arrangement between the Clinical Supervisor and the Provider which describes the Clinical Supervisor's oversight responsibility for the supervision, monitoring, and training of QMHPs and QMHAs for the provision of rehabilitative mental health services. The Clinical Supervisor must provide and document clinical supervision of a QMHP or QMHA at least once every month.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0080
Clinical Record Requirements

All Providers shall:

(1) Develop and maintain an individual legible record for each client which is completed within medically appropriate timeframes. The clinical record must include:

(a) CPMS enrollment data;

(b) Identifying data including the client's name, address, telephone number, date of birth, gender and marital status (if applicable);

(c) Name, address, and telephone number of parent, legal guardian or next of kin;

(d) Name, address and telephone number of the client's physician;

(e) Name and address of the client's physical health plan;

(f) Client Consent to Treatment (if the clinical record does not reflect a signed and dated consent of the client or client representative to the recommended services and Treatment Plan, the record shall document the reason such signature is missing);

(g) A mental health assessment and pertinent history;

(h) Individualized Treatment Plan;

(i) Documentation of client participation in treatment planning;

(j) Medication services records (if applicable);

(k) Discharge criteria and summary; and

(l) Progress notes sufficient to support each service for which a billing is made.

(2) Provide services as specified in the client's Treatment Plan. The Treatment Plan shall be included in the client's clinical record and shall specify:

(a) The DSM Axis I Diagnosis that is the medically appropriate reason for clinical care and the main focus of treatment;

(b) The individualized treatment goals and measurable objectives to be achieved;

(c) The regimen of rehabilitative mental health services described in MHDDSD's Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule, or other approved schedules that will be used to meet the treatment goals and achieve the measurable objectives;

(d) The projected schedule for service delivery, describing the expected amount, duration and scope of each type of planned therapeutic session or service;

(e) The printed name, signature and date of signature of the primary QMHP;

(f) The projected schedule for revising the Treatment Plan at least annually thereafter in conjunction with the annual Comprehensive Mental Health Assessment; and

(g) The criteria for discharge.

(3) Conduct a complete Comprehensive Mental Health Assessment for all clients receiving continual rehabilitative mental health services for more than one year from date of enrollment. The Comprehensive Mental Health Assessment shall be completed by a QMHP and reviewed and approved, in writing, at least annually by the LMP. The Comprehensive Mental Health Assessment will:

(a) Include the following treatment domains:

(A) Cognitive;

(B) Family;

(C) Substance abuse;

(D) Emotional;

(E) Behavioral;

(F) Developmental;

(G) Social;

(H) Physical health/medical care;

(I) Nutritional;

(J) School or vocational;

(K) Cultural; and

(L) Legal.

(b) Conclude with a completed DSM five axes diagnosis followed by a clinical formulation and a revised Treatment Plan.

(4) Document delivery of prescribed services through progress notes. This documentation, at a minimum, shall consist of material which includes:

(a) The specific Medicaid service rendered;

(b) The date service was rendered;

(c) The printed or stamped name of the QMHP or QMHA who rendered the service;

(d) The setting in which the service was rendered;

(e) The amount of time it took to deliver the service;

(f) Client's clinical response to the specific treatment; and

(g) The signature, computerized signature or written initials and date of this authentication and educational credentials of the QMHP or QMHA providing the service. If written initials are utilized to authenticate a progress note, the Provider must maintain a printed list of staff with their corresponding initials. A stamped signature may be utilized if the QMHP or QMHA also authenticates this signature by initialing and dating the stamped signature.

(5) For services that are not specifically included in the client's Treatment Plan, or exceed the scope of the plan, maintain an explanation of how the services being billed relate to the Treatment Plan.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 6-1988, f. & cert. ef. 6-16-88; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-917; MHD 3-1994(Temp), f. & cert. ef. 4-15-94; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0085
Additional Provider Requirements

All Providers shall:

(1) Maintain fiscal records in accordance with accounting principles approved by the American Institute of Certified Public Accountants and/or other applicable accounting guidelines;

(2) Establish a schedule of fees for billable services based upon the reasonable and allowable costs of the services as determined by MHDDSD in accordance with OMB Circular A-122 or other applicable state and federal laws, rules and regulations. Billings for Medicaid paid services shall in no case exceed the usual and customary charges to private clients for any like item or service charged by the Provider;

(3) Accept payment from MHDDSD as full and total reimbursement for services provided;

(4) Comply with these rules and the applicable General Rules for Oregon Medical Assistance Programs OAR 410-120-0000 through 410-120-1980 published by OMAP and all applicable MHDDSD

Office of Mental Health Services (OMHS) rules. Sanctions may be imposed on a Provider for abuse or misutilization of Medicaid as described in OAR 410-120-0000 through 410-120-1980 of the General Rules for Oregon Medical Assistance Programs.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0088
Quality Assurance Requirements

In accordance with OMHS Administrative Rules, all Providers will develop and implement a planned, systematic, on-going program for monitoring, evaluating, and improving the quality and appropriateness of rehabilitative mental health Medicaid services provided to clients. For CMHPs only:

(1) The continuous quality improvement program must also assure compliance with this rule and requires the establishment of a Quality Assurance Committee and a written Quality Assurance Plan which together implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based on input from Providers, clients and client representatives;

(2) The Quality Assurance Committee shall develop and carry out the Quality Assurance Plan and shall be the catalyst for improvement in the organization's clinical outcomes. The Quality Assurance Committee shall be composed of:

(a) One or more QMHPs, including an LMP (for programs serving children, a child psychiatrist is preferred) who are representative of the scope of services delivered;

(b) A representative or representatives of the clients and families served;

(c) Other persons who have the ability to identify, design, measure, assess and implement clinical and organizational changes; and

(d) Other persons as deemed necessary by the CMHP to assure culturally competent and nondiscriminatory services.

(3) The Quality Assurance Committee shall:

(a) Identify indicators of quality;

(b) Identify measurable and time-specific performance objectives;

(c) Identify data sources and methodology to analyze and measure performance;

(d) Develop a process to systematically collect outcome data and identify staff who will collect and analyze data;

(e) Oversee the data collection process;

(f) Analyze the information collected and measure progress toward performance objectives;

(g) Identify clinical and operational changes necessary to achieve performance objectives;

(h) Implement clinical or operational changes that are indicated by the achievement or non-achievement of performance objectives; and

(i) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis.

(4) The Quality Assurance Committee shall meet at least quarterly.

(5) The Quality Assurance Plan must be maintained by the CMHP and shall describe the implementation and ongoing operation of the functions performed by the Quality Assurance Committee. The QA committee shall evaluate the plan at least annually and update it as necessary. The plan shall include the following policies and procedures:

(a) A description of the Quality Assurance Committee's authority to identify and implement clinical and organizational changes;

(b) The composition and tenure of the Quality Assurance Committee and a description of their duties and responsibilities;

(c) The schedule of the Quality Assurance meetings;

(d) Objectives and scope of planned projects or activities for the year;

(e) Planned monitoring of previously identified issues, including tracking issues over time;

(f) Planned evaluation of a Performing Provider, when the Performing Provider does not independently meet the requirements of this rule; and

(g) Planned evaluation of the QI program;

(h) The policies and procedures for identifying and using objective and measurable performance objectives;

(i) The policy and procedures for identifying and using data sources;

(j) The indicators of quality in the following domains:

(A) Access to services;

(B) Quality of care;

(C) Integration and coordination; and

(D) Outreach, education and prevention.

(k) The policies and procedures for reporting, tracking, investigating, and analyzing reports of critical incidents;

(l) The policies and procedures for both reviewing documentation and determining that the staff have the required competencies, and applicable educational credentials, certifications and/or licensures or supervision to perform assigned duties and meet the Provider's performance objectives;

(m) The policies and procedures to monitor underutilization and overutilization of services;

(n) The policies and procedures for reviewing complaint and grievance information and action taken;

(o) The policies and procedures for reviewing Notices of Denials;

(p) The policies and procedures for the assessing and improving client satisfaction;

(q) The policies and procedures for clinical records review to assure conformance with OAR 309-016-0080 and other applicable MHDDSD rules; and

(r) The policies and procedures to assure resources such as personnel, analytic capabilities and data resources are adequate to meet the needs of the QA/QI program.

(6) The QA Committee shall maintain:

(a) A written QA Plan available for review by the MHDDSD upon request;

(b) Minutes from each meeting which identifies action items, persons responsible and target dates for each task and a written summary of the pertinent facts and conclusions of each Quality Assurance Committee meeting for review by the MHDDSD;

(c) A written annual summary of the QA/QI program for review by the MHDDSD. This summary shall:

(A) Demonstrate compliance with the QA/QI Plan;

(B) Evaluate the findings of the QA Committee relative to the performance objectives and specific actions taken to continually improve performance throughout the organization.

(C) Demonstrate that the QA Plan sets in place a continuous cycle of measurement and feedback leading to clinical services improvement; and

(D) Include a report of each Performing Provider's compliance with the QA/QI Plan.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0095
Scope of Medical Assistance Program Coverage — Fee-For-Service

(1) Payment for rehabilitative mental health services is available for services to Medicaid-eligible clients within the limitations established by MHDDSD through the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule or other approved schedules.

(2) MHDDSD is not liable for Medicaid payment for treatment and treatment planning beyond limits stated in these rules or the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule or other approved schedules.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0100
Priorities for Services to Adults With Mental or Emotional Disorders

Within the limits of available funds, services to persons 21 years of age and older with mental or emotional disorders shall be provided in the following order of priority:

(1) Persons who, in accordance with the assessment of professionals in the field of mental health, are:

(a) At immediate risk of hospitalization due to a mental or emotional disorder;

(b) In need of continuing services to avoid hospitalization due to a mental or emotional disorder; or

(c) Pose a hazard to the health and safety of themselves or others due to a mental or emotional disorder.

(2) Persons who, in accordance with the assessment of professionals in the field of mental health, are experiencing mental or emotional disorders not requiring hospitalization in the near future, but which significantly impact their ability to function in everyday life. This includes individuals served previously in order to provide continuity of care, ensure stability and maintenance, and prevent decompensation.

(3) Persons who, in accordance with the assessment of professionals in the field of mental health, are experiencing mental or emotional disorders and for whom services would be beneficial but not necessary for them to function in everyday life.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0102
Priorities for Services to Children With Mental or Emotional Disorders

Mental health services to Medicaid-eligible children with mental or emotional disorders shall be provided in the following order of priority:

(1) Mental Health Crisis Services:

(a) Children whose level of functioning indicates an emergency psychiatric condition;

(b) Children whose level of functioning indicates an urgent psychiatric condition.

(2) Mental Health Treatment:

(a) Children, who, in accordance with the assessment of professionals in the mental health field:

(A) Are at immediate risk of psychiatric hospitalization or removal from the home due to a mental or emotional disorder;

(B) Exhibit behavior which indicates a high risk of developing disorders of a severe or persistent nature;

(C) Have a severe mental or emotional disorder.

(b) Any other Medicaid-eligible child who is experiencing mental or emotional disorders which significantly affect the child's ability to function in everyday life, but do not require hospitalization or removal from his or her home in the near future.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 4-1993, f. & cert. ef. 11-30-93; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0105
Billing Requirements

(1) All Providers:

(a) Shall not bill clients for the cost of treatment; and

(b) Must pursue potential third-party payments from Medicare, health insurance, or other sources that may cover services rendered. Any such payments received must be indicated on billings to OMAP;

(c) Must bill MHDDSD at a rate, based upon reasonable and allowable costs of services in accordance with OMB Circular A-122 or other applicable state and federal laws, rules and regulations, not in excess of the Provider's usual and customary charge to the general public. Rates charged are subject to review by MHDDSD. Payment will not exceed rates established by MHDDSD Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule or other applicable schedules;

(d) Submit all fee-for-service billings to the Office of Medical Assistance Programs Medicaid Management Information System (MMIS) electronically or on forms designated by that office or through other systems as directed by MHDDSD. Procedure codes listed in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule must accurately describe services rendered and must be used when billing.

(2) Fee-for-service claims must be filed within 12 months of the date of service to be eligible for payment.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 6-1988, f. & cert. ef. 6-16-88; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0110
Payment Limitations

(1) Payment will be made at each Provider's usual and customary charge or MHDDSD's reimbursement rates, whichever is less, minus payments received or due from other payors. Payments to other specified Providers will be made according to other approved schedules:

(a) For Performing Providers:

(A) Limitations contained in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule, such as the maximum rate and the amount, duration, and scope of services provided, are subject to change at the discretion of MHDDSD. Providers will be notified of such changes in writing;

(B) Payment will be made for services listed in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule which are rendered to Medicaid-eligible clients by qualified staff meeting the definition of OAR 309-016-0005(58) and 309-016-0005(59) during the period in which the Provider is enrolled in the Oregon Medical Assistance Program.

(b) For SOSCF or OYA Contracted Residential Programs payment will be made prospectively based on an established daily rate. No other rehabilitative mental health services may be billed by the SOSCF or OYA Residential Program or any other Provider on any date that residential treatment services are billed by the SOSCF or OYA Contracted Residential Program for an individual child.

(2) When MHDDSD determines an overpayment has been made to a Provider, the amount of overpayment is subject to recovery by MHDDSD. The overpayment amount will be determined at MHDDSD's discretion through direct examination of claims, through statistical sampling and extrapolation techniques or other means. Procedures for recovery of funds are as described in the Office of Medical Assistance Programs General Rules for Oregon Medical Assistance Programs or by applicable contract language.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0115
Variances

A variance from those portions of these rules that are not derived from federal regulations or the General Rules for Oregon Medical Assistance Programs may be granted to a CMHP for a period of up to one year in the following manner:

(1) The CMHP shall submit to the MHDDSD Title XIX Section a written request which includes:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed; and

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(2) The Assistant Administrator of the Office of Finance shall approve or deny the request for variance in writing.

(3) The MHDDSD Title XIX Section shall notify the Provider of the decision. MHDDSD shall give notice in writing within 30 days of receipt of the request.

(4) Appeal of the denial of a variance request shall be to the Administrator of MHDDSD, whose decision shall be final.

(5) All variances must be reapplied for annually.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1987, f. 6-29-87, ef. 7-1-87; MHD 1-1991(Temp), f. 1-30-91, cert. ef. 1-31-91; MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0120
Confidentiality of Records Requirements

(1) Providers shall keep all client records confidential in accordance with 42 CFR, Part 431, Subpart F and 42 CFR Part 2, ORS 179.505 and other applicable state federal laws.

(2) Providers, upon request, shall make pertinent clinical and financial eligibility information concerning a client available within ten days to other service Providers responsible for the client's care, consistent with state statutes and federal laws and regulations concerning confidentiality.

Stat. Auth.: ORS 179.505(1), 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 4-1991, f. & cert. ef. 7-29-91; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0130
Requirements for Rehabilitative Mental Health Services in SOSCF or OYA Contracted Residential Programs

(1) The MAS in the county in which the child resides will maintain a list, on file, of all authorized Service Authorization Forms by case name, Provider name, the amount, duration and scope of the services authorized, dates of the authorization and other data required.

(2) Prior to admission or no later than 15 days after an emergency placement in an SOSCF or OYA Contracted Residential Program, the MAS in the county in which the child resides will determine the need for rehabilitative mental health services to be provided in an SOSCF or OYA Contracted Residential Program. No later than 15 working days after receiving an SOSCF or OYA Residential referral package the MAS will:

(a) Review the application;

(b) Assess the child's level of functioning and severity of problems based on information in the referral and/or face-to-face assessment;

(c) Determine the need for rehabilitative mental health treatment in a residential setting using a standardized measure provided by MHDDSD and the admission criteria listed in OAR 309-016-0130(3); and

(d) Complete the Service Authorization Form and return it to the SOSCF or OYA caseworker with the referral package. The referral package must be complete and current within the last 12 months.

(3) Children receiving rehabilitative mental health services in an SOSCF or OYA Contracted Residential Program must meet the following admission criteria:

(a) The child has a DSM diagnosis on Axis I of a completed five axes diagnosis; and

(b) The child's condition is not manageable in the child's current living situation; or

(c) The child cannot reside at home due to the family's level of functioning; and

(d) Less restrictive or intensive services are not adequate to meet the child's needs based on documented lack of response to prior treatment or clinical judgment of the MAS from the child's home county, the SOSCF or OYA caseworker, and the clinical staff of the residential program.

(4) Within 30 days of admission, the SOSCF or OYA caseworker and the SOSCF or OYA Contracted Residential Program shall develop the clinical criteria for discharge. The discharge criteria shall consist of measurable objectives and shall be placed in the clinical record.

(5) The MAS from the county in which the SOSCF or OYA Contracted Residential Program is located must authorize the amount, duration and scope of rehabilitative mental health services delivered in an SOSCF or OYA Contracted Residential Program in writing at least once every three months. This authorization must be included in the child's clinical record. Authorization for continuation of rehabilitative mental health services must meet at least one of the following criteria:

(a) Symptoms or behaviors persist at a level of severity documented upon admission and the projected time frame for attainment of treatment goals has not been reached as documented in the Treatment Plan;

(b) The child's and/or family's progress toward identified treatment goals for this level of care has been documented but not all treatment goals have been reached;

(c) No progress toward treatment goals has been documented and the Treatment Plan has been modified to introduce further evaluation in order to clarify the nature of the identified problems and/or new therapeutic interventions have been initiated; or

(d) New symptoms or maladaptive behaviors have appeared while the child is in the residential setting. Treatment of these symptoms and behaviors has been incorporated into a revised Treatment Plan. The new symptoms and/or maladaptive behaviors justify continuation of treatment and may be treated safely and effectively with this level of care.

(6) The MAS in the county in which the residential program is located shall identify or assist the SOSCF or OYA caseworker and the program to identify children appropriate for planned discharge in the next 30 days according to at least one of the following criteria:

(a) Targeted symptoms and/or maladaptive behaviors have abated to the child's baseline level, as documented by attainment of goals for this level of care in the Treatment Plan;

(b) The child exhibits new symptoms or maladaptive behavior which may not be treated safely or effectively at this level of residential care and the child meets admission criteria for a more intensive or restrictive level of care; or

(c) No progress toward treatment goals has been documented for a six-month period of time, and appropriate Treatment Plan review and revision has taken place.

(7) Planned discharges require a 30-day notification to the MAS in the county in which the program is located, the MAS in the county where the child lived at admission and the child's SOSCF or OYA caseworker.

(8) In the case of emergency admissions for acute psychiatric hospitalization, the SOSCF or OYA Contracted Residential Program will notify the MAS and the SOSCF or OYA caseworker in the county in which the program is located within one working day. Upon discharge from the hospital the MAS will authorize the need for continued rehabilitative mental health services in the residential program.

(9) When a resident child has an unauthorized absence, the SOSCF or OYA Contracted Residential Program must give notification within one working day to the MAS in the county in which the program is located and to any person having custody of the child. The residential program, the MAS in the county in which the program is located and the SOSCF or OYA caseworker will jointly decide the appropriateness of returning the child to the program.

(10) A request for reconsideration of admission or discharge decisions made by the MAS must be submitted in writing to the local CMHP within three working days. The CMHP Director, in consultation with an independent psychiatrist, will review the record against the criteria in 309-016-0130 and issue a written decision to the treatment team and the Executive Director of the SOSCF or OYA Contracted Residential Program within seven working days of receipt of the appeal.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 2-1993(Temp), f. 5-27-93, cert. ef. 6-1-93; MHD 4-1993, f. & cert. ef. 11-30-93; MHD 3-1994(Temp), f. & cert. ef. 4-15-94; MHD 7-1994, f. & cert. ef. 10-12-94; MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0140
Client Complaint Process

(1) Clients may choose to file a written complaint with the provider to resolve a disagreement with the provider.

(2) Clients should attempt to resolve the issues through the complaint process before requesting an administrative hearing for the following reasons:

(a) It is more expeditious (a decision will be made within 30 calendar days after receipt of the completed complaint form by the provider);

(b) It is less formal;

(c) It is less costly; and

(d) It does not result in the loss of the right to request a hearing.

(3) Clients shall lose their right to the complaint process concerning specific issue(s) if they request an administrative hearing before receiving a decision from the provider about a complaint made related to the issue(s).

(4) The client or client representative shall file a complaint within 30 calendar days from the date of written notice of denial of covered services or the date dissatisfaction with a provider occurred:

(a) The client or client representative shall fully complete the complaint form and shall submit the complaint form to the provider;

(b) If an oral complaint is received, the individual receiving the complaint shall describe the complaint process, provide written materials and request the client or client representative to put the complaint in writing using the complaint form;

(c) The complaint shall be handled as described below when the client or client representative has made a complaint but has not requested a hearing:

(A) The provider shall review the complaint and determine whether the 30-day time period for making a complaint has expired. If the time period for making a complaint has expired, the provider shall determine whether the client or client representative had good cause for making a late complaint:

(i) If the provider determines that good cause for filing a late complaint does not exist, the provider shall notify the client that the complaint will not be addressed;

(ii) If the provider determines that good cause for filing a late complaint exists, the provider shall proceed to the next step of this procedure.

(B) The provider shall review the complaint and determine whether additional information is needed from the client or client representative and whether the issue can be resolved within 30 calendar days hence;

(C) The provider shall address the complaint within 30 calendar days of receipt by either making a decision on the complaint or notifying the client in writing that a decision regarding the complaint cannot be made within 30 calendar days. This written notice must:

(i) Be issued as soon as it is known that a delay will occur;

(ii) Specify the reason for the delay; and

(iii) State when a decision will be made.

(D) If the provider determines that additional information is needed to address the complaint, the provider shall notify the client or client representative that additional information is needed within 10 calendar days from the date of notification or another mutually agreed upon time frame;

(E) If the client or client representative fails to provide the requested information within the 10 calendar days or the mutually agreed upon time frame, the complaint may be resolved against the client;

(F) The provider shall issue to the client a written decision on the complaint which specifically addresses each element of the complaint. If the decision is adverse, the written notice shall include all elements of a notice of denial and shall include as enclosures the Notice of Hearing Rights and the Administrative Hearing Request form.

(d) The complaint shall be handled, as described below, when the client or client representative has made a complaint and requested a hearing before receiving a decision about the complaint:

(A) The provider shall issue a letter to the client informing the client that the issue will not be addressed through the complaint process unless the request for hearing is withdrawn;

(B) The provider shall begin the process of establishing the facts concerning the hearing issue.

(5) The client and/or client representative shall cooperate with the provider in gaining access to records relevant to the complaint by consenting to a release of information to the provider to the extent necessary to resolve any complaint made. Failure to consent may make it impossible to resolve the complaint.

(6) If the client or client representative believes that the client's health is at risk of deteriorating during the period of time required to resolve the complaint issue, then the client or client representative may file an expedited complaint. In addition to the information required by the complaint form, the client or client representative shall do the following:

(a) Identify the issue as an expedited complaint;

(b) Explain the medical urgency of resolving the issue; and

(c) Describe the negative consequences of following the regular complaint process.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0150
Expedited Client Complaint Process

(1) Upon receipt of an expedited complaint, the provider representative shall collect documents relevant to the expedited issue. The client or client representative may be asked to consent to a release of information to the provider to the extent necessary to resolve the complaint. Any delay in receipt of records shall extend the time period for making a decision about the need for an expedited complaint. The extension shall equal the delay in receiving records.

(2) The provider shall forward information collected to the clinical director, or designee(s) of the clinical director, as soon as available. This information shall include preauthorization documents; notification of denial; and clinical records supporting the denial and degree of urgency of the issue.

(3) The clinical directors or designees shall review documentation received to determine if the mental health condition at issue meets the definition of an emergency situation or urgent situation.

(4) The clinical directors or designees shall notify the designated staff member responsible for handling complaints of the decision in writing and the basis for that decision.

(5) The designated staff member shall notify the client in writing of the decision about the expedited request.

(6) If an expedited complaint has been granted, the provider shall convene a complaint review group to address the complaint within five working days.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0160
Provider Responsibilities in the Client Complaint Process

Providers shall have the following responsibilities in resolving disagreements with clients:

(1) Written procedures for accepting, documenting, processing, analyzing, resolving and responding to all complaints requested by clients;

(2) Designated staff members to resolve complaints received by clients. The designees shall be persons with the authority and expertise necessary to make final clinical or administrative decisions at the provider level;

(3) A method of informing clients about complaint procedures. Information provided to clients shall include:

(a) Written and posted material describing these processes;

(b) Assurance of confidentiality;

(c) Applicable complaint process forms; and

(d) Assurance that client rights to make a complaint are protected.

(4) A procedure to notify the client when a denial of covered services occurs. The notification shall include:

(a) A statement of the intended action, the effective date of such action, and the date the written notice is mailed. The effective date of an intended action shall be set at least 10 calendar days after the date of notice unless one or more of the following conditions apply:

(A) The provider has received confirmation of the death of a client;

(B) The provider has received a written statement signed by a client or client representative that he or she no longer wishes treatment or gives information that requires a denial of services and indicates that he or she understands that this might be the result of supplying that information;

(C) The client has been admitted to an institution;

(D) The client's whereabouts are unknown and the post office returns mail directed to the client indicating no forwarding address; or

(E) A change in the level of mental health services is prescribed by the client's LMP.

(b) The reason(s) for the intended action and the specific rules or regulations that support the action;

(c) An explanation of the client's right to file a complaint with the provider or to request an administrative hearing with MHDDSD, and the consequences of choices made. (The provider shall encourage the client or client representative to use the complaint procedure, but shall not discourage the client or client representative from requesting a hearing);

(d) A statement referring the client or client representative to an enclosed Notice of Complaint Process;

(e) A statement referring the client or client representative to an enclosed Notice of Hearing Rights; and

(f) The name and telephone number of the provider representative to contact for additional information.

(5) A procedure to forward to the Quality Assurance Committee of MHDDSD an analysis of complaints received;

(6) Provisions for reviewing the internal complaint processes;

(7) A procedure for retaining the following documents regarding complaints in a central location for a minimum of two calendar years from the date of the resolution:

(a) Log of complaints received;

(b) File of written complaints received;

(c) Records of the review or investigation;

(d) Resolution of complaints received; and

(e) The name and title of the designated staff member making the resolutions, determinations or decisions.

(8) Afford clients the full use of the complaint procedures;

(9) Cooperate with MHDDSD and the client or client representative in seeking a remedy to the complaint issue and comply with and fully implement any decision. Providers shall:

(a) Not penalize the client or client representative for making a complaint or requesting a hearing;

(b) Render a decision about a complaint within 30 calendar days of receiving the complaint form;

(c) Cooperate in the hearing process and make available, as determined necessary by MHDDSD, all persons with relevant information and all pertinent files and clinical records;

(d) Not deny treatment until a decision is rendered after the hearing or complaint if a client or client representative requests a hearing or makes a complaint before the intended date of action.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0170
Client Hearing Process

(1) The Oregon Attorney General's Uniform and Model Rules of Procedure under the Administrative Procedures Act apply to client hearings process (OAR 137-003-0001 through 137-003-0092 and 137-004-0010). Clients may choose to request an administrative hearing to resolve a complaint with a provider in the following manner:

(a) Wait for a decision to be made on a complaint before requesting a hearing;

(b) Request a hearing prior to a decision being made related to a complaint (this choice will stop the complaint process regarding the issue(s) involved);

(c) Accept the decision made related to a complaint and not request a hearing; or

(d) Request an administrative hearing directly from the MHDDSD Title XIX Section.

(2) The time frame for requesting a hearing shall be within 45 calendar days after the date of:

(a) The decision related to the complaint;

(b) The initial notification of denial of covered services; or

(c) The date of initial dissatisfaction with the provider.

(3) If the client or client representative chooses to request a hearing, the client or client representative shall complete and sign an Administrative Hearing Request form (AFS 443) or other MHDDSD approved form and shall send it to the MHDDSD Title XIX Section.

(4) The client or client representative may request a postponement of a hearing or may withdraw a hearing request by making a written request to the MHDDSD Title XIX Section.

(5) The client or client representative shall cooperate with MHDDSD and the provider in gaining access to records relevant to the hearing issue by consenting to a release of information to MHDDSD and the provider to the extent necessary to resolve a hearing issue. Failure to consent may make it impossible to resolve the hearing issue. Untimely receipt of records shall serve as a valid reason for MHDDSD or the provider to request a postponement of the scheduled hearing.

(6) If the client believes that his or her health is at risk of deteriorating during the period of time required to resolve the hearing issue, then the client may request an expedited hearing. In addition to the information required by the Administrative Hearing Request form, the client or client representative shall do the following:

(a) Identify the issue as an expedited hearing request;

(b) Explain the urgency of resolving the issue; and

(c) Describe the negative consequences of following the regular hearing request process.

(7) A hearing officer, after weighing the evidence, will issue a proposed final order. MHDDSD may adopt or modify the order, or reject the order and prepare a new one.

[ED. NOTE: The forms referenced are available from the agency.]
Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0180
Client-Expedited Hearing Process

(1) Upon receipt of an expedited hearing request, the MHDDSD representative shall immediately notify the provider of the expedited hearing request and begin collecting documents relevant to the request. The client may be asked to consent to a release of information to MHDDSD and to the provider to the extent necessary to resolve the hearing issue. Any delay in receipt of records shall extend the time period for making a decision about the need for an expedited hearing.

(2) The MHDDSD representative shall forward information collected to the clinical directors or designees, as soon as available. These documents shall include:

(a) Preauthorization documents;

(b) Denial notifications; and

(c) Clinical records supporting the denial and the degree of urgency of the issue.

(3) The clinical directors or designees shall review documentation received to determine if the mental health condition at issue meets the definition of an emergency or urgent situation.

(4) The clinical directors or designees shall notify the MHDDSD representative responsible for handling hearings of the decision and the basis for that decision.

(5) The MHDDSD representative shall notify the client and the contracted Hearing Officer or Hearing Unit of the decision about the expedited request.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0190
Procedures for Client Hearings

(1) Upon receipt of the Administrative Hearings request, MHDDSD shall forward the request and any supporting documentation to a Hearings Officer or Hearing Unit under contract with MHDDSD.

(2) MHDDSD shall forward a copy of the Administrative Hearing Request, supporting documentation, and the notice of hearing to the provider:

(a) If a client or client representative requests a hearing before the intended date of action described in the advance notice about the intent to deny treatment, the provider may not deny treatment until a decision is rendered after the hearing;

(b) The provider shall promptly notify the client in writing that:

(A) Services are to be continued until a hearing decision is rendered; and

(B) The cost of any services provided to the client based on the hearing issue will be recovered from the client if the Hearing Officer finds in favor of the provider and MHDDSD accepts the findings of the Hearing Officer.

(3) The provider shall collect documentation relevant to the case and have it reviewed by the clinical director or designee of the clinical director to determine if the case was handled correctly:

(a) If the clinical director or designee of the clinical director determines the case was handled incorrectly, he or she shall inform the client of how the issue will be addressed and shall determine whether or not the client is satisfied. The MHDDSD representative shall send a written notice to the Hearings Officer or Hearing Unit that the issue is settled if the client is satisfied;

(b) If the clinical director or designee of the clinical director determines the case was handled correctly and the original decision stands, then he or she shall identify witnesses to testify during the hearing, prepare a letter stating the position of the organization concerning the issue and forward copies of all evidence to the MHDDSD representative.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0200
Time Period Computation

The time period for filing a complaint or requesting a hearing shall be computed as follows:

(1) The day the complaint or hearing request is received by MHDDSD shall not be included;

(2) The last day of the time period shall be included unless it is a Saturday, Sunday or a legal holiday;

(3) If the last day is a Saturday, Sunday or a legal holiday, the time period shall include the next day which is not a Saturday, Sunday or a legal holiday.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0210
Confidentiality and Release of Information

(1) All information concerning a complaint made or a hearing requested shall be kept confidential by the parties. MHDDSD and the provider shall have a right to this information without a signed release from the client or client representative.

(2) The client or client representative may be asked to consent to the release of information to MHDDSD and the provider to the extent necessary to resolve the complaint or hearing request. Failure to consent may make it impossible to resolve the complaint or hearing request.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96; MHD 7-1997, f. & cert. ef. 10-1-97

309-016-0220
Provider Appeals Process

The Oregon Attorney General's Uniform and Model Rules of Procedure under the Administrative Procedures Act apply to provider appeals (OAR 137-003-0001 through 137-003-0092 and 137-004-0010).

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

309-016-0230
Provider Appeals — Appeal of Payment/Sanction Decisions

A provider may appeal certain decisions affecting the provider made by MHDDSD by requesting an administrative review, or a contested case hearing. Providers may appeal:

(1) A denial of or limitation of payment allowed for services or items provided;

(2) Sanctions imposed, or intended to be imposed, by MHDDSD; or

(3) Overpayment determinations.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 5-1996, f. & cert. ef. 4-2-96

Oregon Health Plan Non-Capitated Outpatient Mental Health Services

309-016-0300
Purpose and Statutory Authority

(1) Purpose. These rules:

(a) Prescribe general standards for the provision of non-capitated outpatient mental health services under the Oregon Health Plan via a fee-for-service payment mechanism to clients eligible for payment under Title XIX (Medicaid) of the Social Security Act, Section 1905(a)(13) and Federal Regulations at **42 CFR 440.130(3)(d)**; and

(b) Define procedures for billing State of Oregon for non-capitated outpatient Medicaid reimbursable mental health services delivered to Medicaid eligible individuals who are not enrolled with MHOs. The rules do not apply to fee-for-service reimbursements made by an MHO to a subcontractor for services which are capitated in the MHO agreement.

(2) Statutory Authority. These rules are authorized by ORS 414.640(2) and 430.041 and carry out the provisions of ORS 414.640(2) and 430.021(2).

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.740(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0310
Definitions

As used in these rules:

(1) "Action" means a denial of Medicaid-covered services;

(2) "Amount" means the number and frequency of treatment sessions provided;

(3) "Client" means a Medicaid-eligible individual with a mental or emotional disorder who requests or receives non-capitated outpatient mental health services;

(4) "Client Process Monitoring System" or "CPMS" means the MHDDSD's client information system for community-based services;

(5) "Client Representative" means a person designated by a client as permitted in ORS 430.210(3) to assert and exercise the client's rights under ORS 430.210;

(6) "Clinical Record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services. The record is a collection of all documentation regarding a client's mental health treatment services. It is a legal document and provides the basis by which the provider manages service delivery and quality assurance. For the purpose of confidentiality, it is considered the medical record defined in ORS Chapter 179;

(7) "Clinical Supervision" means the documented oversight by a Clinical Supervisor of outpatient mental health treatment services provided by Qualified Mental Health Professionals (QMHPs) or Qualified Mental Health Associates (QMHAs);

(8) "Clinical Supervisor" means a designated QMHP with a Master's degree and at least two years post-graduate clinical experience in a mental health treatment setting. The Clinical Supervisor operates within the scope of his or her practice and demonstrates the competency to oversee and evaluate the outpatient mental health treatment services provided by a QMHP or QMHA;

(9) "Community Mental Health Program" or "CMHP" means the organization of all services under ORS 430.630 for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a Local Mental Health Authority, operated in a specific geographic area of the state under a contract or agreement with the MHDDSD;

(10) "Comprehensive Mental Health Assessment" means a mental status exam and an evaluation of a client's functioning in the treatment domains described in OAR 309-016-0390(3) completed by a QMHP;

(11) "Consent to Treatment" means a written agreement between the client or the client representative and the provider for the client to receive outpatient mental health services;

(12) "Corrective Action Plan" means a written document which specifies actions that a provider will take to come into compliance with OAR 309-016-0300 through 309-016-0550;

(13) "Direct Supervision" means the directing and coordinating by a QMHP of interventions performed by a QMHA. Direct supervision also means reviewing and evaluating the documentation of interventions by a QMHA. Direct supervision is performed on a regular, routine basis either individually or in a group setting;

(14) "Discharge Criteria" means the individualized standards to be met to complete service provision for each client;

(15) "DSM Diagnosis" means the determination of a client's mental or emotional disorder as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The principal Axis I diagnosis provides the clinical basis for treatment, is determined through the Mental Health Assessment and any examinations, tests, procedures, or consultations suggested by the assessment and is entered on a written individualized Treatment Plan. Neither a DSM "V" code condition, substance use disorder or mental retardation may be considered the principal diagnosis supporting eligibility for services under these rules, although these conditions or disorders may co-occur with the diagnosable mental disorder.

(16) "Duration" means the length of time used to provide:

(a) Specific treatment sessions; and

(b) An entire course of treatment.

(17) "Fee-For-Service" or "FFS" means the payment for each reimbursable service retrospectively based upon cost of providing the service, or the maximum rate approved by the MHDDSD for such service, whichever is less;

(18) "Fully Capitated Health Plans" or "FCHPs" means Prepaid Health Plans that contract with OMAP to provide physical health care services under the OHP Medicaid Demonstration Project. In order to

provide services under these rules, an FCHP must also be a Mental Health Organization;

(19) "Goal" means an expected result or condition to be achieved, which is specified in a statement of relatively broad scope, provides a guideline for the direction of care and is related to an identified clinical problem as stated on the Treatment Plan;

(20) "Hearing" means:

(a) For clients, an administrative hearing related to a denial of benefits which is held when requested by a client or client representative. A hearing may also be held when requested by a client or client representative who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously; or

(b) For providers, an administrative hearing regarding appeal of:

(A) A denial of or limitation of payment allowed for services or items provided;

(B) Sanctions imposed, or intended to be imposed, by the MHDDSD; or

(C) Overpayment determinations.

(21) "Licensed Medical Practitioner" or "LMP" means a person who meets the following minimum qualifications as documented by the provider:

(a) Holds at least one of the following educational degrees and valid licensures:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon; or

(C) Physician's Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(22) "Medical Supervision" means an LMP's determination at least annually and at intervals prescribed by the Office of Mental Health Services (OMHS), of the medical appropriateness of outpatient mental health services for each client;

(23) "Medically Appropriate" means the determination by an LMP, operating within the scope of his or her license, training and experience, that a service is required for prevention (including preventing a relapse), diagnosis or treatment of mental health conditions and is appropriate and consistent with the diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental condition; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the client or provider of the service; and the most cost effective of the alternative levels of medically appropriate services which can be safely and effectively provided to the client;

(24) "Mental Health and Developmental Disability Services Division" or "MHDDSD" means the Department of Human Services (DHS) Agency responsible for the administration of State mental health and developmental disability services to persons who qualify for certain programs under federal and state laws, rules and regulations;

(25) "Mental Health Assessment" means a determination by a QMHP during the enrollment process and periodically thereafter as medically appropriate of the client's need for outpatient mental health services. It involves collection and assessment of data pertinent to the client's mental health history and current mental health status through interview(s), observation, testing, and review of previous treatment records. The activities conclude with:

(a) A determination of a DSM Axis I diagnosis, which provides the clinical basis for treatment, and is entered on a written Treatment Plan; or

(b) A written statement, supported by assessment and interview data, which indicates that the person is not in need of outpatient mental health services. Other disposition information such as to whom the person was referred and the date the Notice of Denial was given or sent shall be included in the statement.

(26) "Mental Health Organization" or "MHO" means a Prepaid Health Plan under an Intergovernmental Agreement or contract with the MHDDSD that provides outpatient mental health services under the Oregon Health Plan. MHOs can be FCHPs, CMHPs, county governments operating CMHPs, or private MHOs or combinations thereof;

(27) "MHO Agreement" means the written contract or Intergovernmental Agreement between the MHDDSD and an MHO as permitted in ORS 414.725 for provision of mental health services under the Oregon Health Plan;

(28) "Notice of Denial" means the notice given or sent to the client upon denial, termination, suspension or reduction of services which explains the client's right to appeal such a decision and the process to appeal such a decision;

(29) "Objective" means the written statement of an expected result or condition that is related to the attainment of a goal. The objective is stated in measurable terms and has a specified time for accomplishment;

(30) "Office of Medical Assistance Programs" or "OMAP" means the Office of the Oregon Department of Human Services responsible for coordinating the Medical Assistance Programs within the State of Oregon;

(31) "Office of Mental Health Services" or "OMHS" means the program office of the MHDDSD responsible for the admin-istration of mental health services for the State of Oregon;

(32) "OMB Circular A-122" means the Circular established by the Federal Office of Management and Budget which sets forth the principles for determining costs of grants, contracts and other agreements;

(33) "Outpatient Mental Health Services" means those FFS services listed in the MHDDSD Medicaid Rehabilitative Services Procedures Codes and Reimbursement Rates Schedule. The QMHP or QMHA must provide these FFS services upon the recommendation or under the medical supervision of an LMP. The services must be provided either by a:

(a) Licensed Medical Practitioner (LMP);

(b) Qualified Mental Health Professional (QMHP) under clinical supervision of a Clinical Supervisor; or

(c) Qualified Mental Health Associate (QMHA) under the direct supervision of a QMHP and under clinical supervision of a Clinical Supervisor.

(34) "Progress" means the movement toward the individual treatment goal(s) using criteria in the client's treatment plan, set by the provider, and if exercised under ORS 430.210(3), the client, the client's guardian, and any representative designated by the client;

(35) "Progress Note" means the written documentation of the clinical course of treatment which becomes the basis for review and revision of the Treatment Plan and the clinical course of treatment;

(36) "Provider" means an MHO subcontractor providing outpatient mental health services under these rules;

(37) "Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the provider:

(a) A bachelor's degree in a behavioral sciences field; or

(b) A combination of at least three year's relevant work, education, training or experience; and

(c) Has the competencies necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and

(C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

(38) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the provider:

(a) Graduate degree in psychology;

(b) Bachelor's degree in nursing and licensed by the State of Oregon;

(c) Graduate degree in social work;

(d) Graduate degree in a behavioral science field;

(e) Graduate degree in recreational, art, or music therapy;

(f) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(g) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial

DSM diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family, and/or group therapy within the scope of his or her practice.

(39) "Quality Assurance" or "QA" means the structured, internal monitoring, and evaluation process to:

(a) Identify aspects of quality care;

(b) Use indicators and clinical criteria to continually and systematically monitor these aspects of care;

(c) Establish markers which indicate problems or opportunities to improve care;

(d) Take action to correct problems and improve substandard care;

(e) Assess the effectiveness of the actions; and

(f) Document the improvements in care.

(40) "Sanction" means an action against a provider taken by MHDDSD in cases of non-compliance, fraud, misuse or abuse of Medicaid;

(41) "Scope" means the extent or range of the type of outpatient mental health services provided;

(42) "Setting" means the locations at which mental health treatment services are provided. Settings include such locations as mental health offices, an individual's home or school or other identified locations;

(43) "Subcontractor" means an entity operating under a written contract with an MHO for the purpose of delivering mental health services in the Oregon Health Plan;

(44) "Treatment" means a planned, medically appropriate, individualized program of interactive medical, psychological or rehabilitative procedures, therapeutic interventions, experiences, and/or activities designed to rehabilitate, relieve or minimize mental or emotional disorders identified through a Mental Health Assessment and provided by a QMHP or QMHA within the scope of their provider certification;

(45) "Treatment Plan" means a written individualized program of treatment goals, measurable objectives and services to be provided. A QMHP and, if they elect to do so under ORS 430.210(3), the client, client guardian, and client representative, will develop the Treatment Plan which includes the amount, duration and scope of services. The Treatment Plan will be revised and the LMP will approve the plan at least annually.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0320
Conditions of Provider Participation — General

All Providers participating in non-capitated outpatient mental health services shall:

(1) Be contractually affiliated with the MHDDSD or operate under a written subcontract with an MHO to provide OHP services;

(2) Abide by applicable portions of:

(a) These rules;

(b) The Office of Mental Health Services (OMHS) rules;

(c) The General Rules for the Oregon Medical Assistance Program, OAR 410-120-0000 through 410-120-1980; and

(d) The Oregon Health Plan Administrative Rules of the Office of Medical Assistance Programs, OAR 410-141-0000 through 410-141-0860.

(3) Hold a valid Certificate of Approval granted by MHDDSD for each type of service provided;

(4) Be enrolled with OMAP based on written application;

(5) Bill only those services provided after the date OMAP issues a vendor number.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0330
Record Retention Requirements

All providers shall retain complete and legible financial and clinical records in accordance with OAR 166-005-0000 through 166-040-1050 (State Archivist). Financial records shall be retained for a minimum of three years and clinical records shall be retained for a minimum of seven years. If an audit, litigation, research and evaluation, or other action involving the financial or clinical record is started before the end of the established retention period, the financial or clinical record must be retained until all issues arising out of the action are resolved or until the end of the established retention period, whichever is later.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0340
Client Rights

All providers must ensure provision of the client rights in ORS 430.210.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2), 430.021(2) & 430.210
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0350
Medical Supervision

All providers seeking reimbursement for services under these rules shall deliver such services under medical supervision in accordance with this rule and any applicable Office of Mental Health Services (OMHS) rules. Medical supervision shall be secured through a current written agreement, job description, or similar type of binding arrangement between a Licensed Medical Practitioner (LMP) and the provider which describes an LMP's responsibility in determining the medical appropriateness of outpatient mental health services delivered under these rules. The LMP must perform medical supervision at least annually by reviewing the Comprehensive Mental Health Assessment and approving the revised Treatment Plan. Providers will utilize the LMP within the individual's scope of practice. Psychiatrists will be involved when medically appropriate and each program shall assure access to psychiatric services.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0360
Clinical Supervision

All providers shall deliver medically appropriate services under clinical supervision in accordance with these rules and applicable Office of Mental Health Services rules. Clinical supervision includes evaluating the effectiveness of and continued need for mental health treatment services provided. Clinical Supervision shall be secured through a current written agreement, job description, or similar type of binding arrangement between the Clinical Supervisor and the provider which describes the Clinical Supervisor's oversight responsibility for the supervision, monitoring, and training of QMHPs and QMHAs for the provision of outpatient mental health services. The Clinical Supervisor must provide and document clinical supervision of a QMHP or QMHA at least once every month.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0370
Clinical Record Requirements

All providers shall:

(1) Develop and maintain an individual, legible record for each person served under these rules which is completed within medically appropriate timeframes. The clinical record must include:

(a) CPMS enrollment data;

(b) Identifying data including the client's name, address, telephone number, date of birth, gender and marital status (if applicable);

(c) Name, address and telephone number of parent, legal guardian or next of kin;

(d) Name, address and telephone number of the client's physician;

(e) Name and address of the client's physical health plan;

(f) Client Consent to Treatment (if the clinical record does not reflect a signed and dated consent of the client or client representative to the recommended services and Treatment Plan, the record shall document the reason such signature is missing);

(g) A Mental Health Assessment and pertinent history;

(h) Individualized Treatment Plan;

(i) Documentation of client participation in treatment planning;

(j) Medication services records (if applicable);

(k) Progress notes sufficient to describe each service for which a billing is made; and

(l) Discharge criteria and summary.

(2) Provide services as specified in the client's Treatment Plan. The Treatment Plan shall specify:

(a) A DSM Axis I diagnosis that is the medically appropriate reason for service provision and the main focus of treatment;

(b) The individualized treatment goals and measurable objectives to be achieved;

(c) The regimen of outpatient mental health services described in MHDDSD's Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule, or other schedules approved by MHDDSD that will be used to meet the treatment goals and achieve the measurable objectives;

(d) The projected schedule for service delivery, describing the expected amount, duration and scope of each type of planned service;

(e) The printed name, signature and date of signature of the QMHP developing the Plan;

(f) The projected schedule for revising the Treatment Plan at least annually in conjunction with the annual Comprehensive Mental Health Assessment; and

(g) The criteria for discharge.

(3) Conduct a complete Comprehensive Mental Health Assessment for all clients receiving continual outpatient mental health services for more than one year from date of enrollment. The Comprehensive Mental Health Assessment shall be completed by a QMHP and reviewed and approved, in writing, at least annually by the LMP. The Comprehensive Mental Health Assessment will:

(a) Include the following treatment domains:

(A) Cognitive;

(B) Family;

(C) Substance abuse;

(D) Emotional;

(E) Behavioral;

(F) Developmental;

(G) Social;

(H) Physical health/medical care;

(I) Nutritional;

(J) School or vocational;

(K) Cultural; and

(L) Legal; and

(b) Conclude with a completed DSM five axes diagnosis followed by a revised Treatment Plan.

(4) Document delivery prescribed services through progress notes. This documentation, at a minimum, shall consist of material which includes the:

(a) Specific Medicaid services rendered;

(b) Date service was rendered;

(c) Setting in which the service was rendered;

(d) Amount of time it took to deliver the service;

(e) Client's clinical response to the specific treatment;

(f) Printed or stamped name of the QMHP or QMHA who rendered the service; and

(g) Signature, computerized signature or written initials and date of this authentication and educational credentials of the QMHP or QMHA providing the services. If written initials are utilized to authenticate a progress note, the provider must maintain a printed list of staff and with their corresponding initials. A stamped signature may be utilized if the QMHP or QMHA also authenticates this signature by initialing and dating the stamped signature.

(5) For services that are not specifically included in the client's Treatment Plan, or exceed the scope of the plan, a written explanation of how the services being billed relate to the Treatment Plan must be included and their provision specifically approved by the LMP who approved the mental health assessment and treatment plan.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0380
Additional Provider Requirements

All providers shall:

(1) Maintain fiscal records in accordance with accounting principles approved by the American Institute of Certified Public Accountants and/or other applicable accounting guidelines;

(2) Comply with these rules, the OHP Administrative Rules of the Office of Medical Assistance Programs, OAR 410-141-0000 through 410-141-0860, the applicable General Rules for Oregon Medical Assistance Programs, OAR 410-120-0000 through 410-120-1980 published by OMAP and all applicable MHDDSD Office of Mental Health Services (OMHS) rules. Sanctions may be imposed on a provider for abuse or misutilization of Medicaid as described in OAR 410-120-0000 through 410-120-1980 of the General Rules for Oregon Medical Assistance Programs;

(3) Accept payment from MHDDSD as full and total reimbursement for FFS services provided.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0390
Quality Assurance Requirements

All Providers will develop and implement a quality assurance program adequate to monitor, evaluate and improve the quality and appropriateness of services provided to clients under these rules, and to assure compliance with these and all other applicable Division Rules.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0400
Billing Requirements

All providers must:

(1) Bill MHDDSD at a rate, based upon reasonable and allowable costs of services in accordance with OMB Circular A-122 or other applicable federal laws, rules and regulations, or the provider's usual and customary charge to the general public, or rates established by MHDDSD Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule whichever is less;

(2) Submit all fee-for-service billings to the Office of Medical Assistance Programs Medicaid Management Information System (MMIS) electronically or on forms designated by that office or through other systems as directed by MHDDSD. Procedure codes listed in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule must accurately describe services rendered and must be used when billing;

(3) File claims within 12 months of the date of service to be eligible for payment.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0410
Payment Limitations

Payment will be made according to:

(1) The limitations contained in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule, such as the maximum rate and the amount, duration, and scope of services provided, are subject to change at the discretion of MHDDSD. Providers will be notified of such changes in writing;

(2) Payment will be made only for services listed in the Medicaid Rehabilitative Services Procedure Codes and Reimbursement Rates Schedule under BA Codes 008 through 399, which are mental health services that are listed and funded under ORS 414.720 at the time of their provision, and which are rendered to Medicaid-eligible clients in full compliance with these rules. Such payments will only be made for services delivered during the period in which the provider is enrolled in the Oregon Medical Assistance Program;

(3) When MHDDSD determines an overpayment has been made to a provider, the amount of overpayment is subject to recovery by MHDDSD. The overpayment amount will be determined at MHDDSD's discretion through examination of all claims, through statistical sampling and extrapolation techniques or other means. Procedures for recovery of funds are as described in the Office of Medical Assistance Programs General Rules for Oregon Medical Assistance Programs or by applicable contract language.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0420
Variances

A variance from those portions of these rules that are not derived from federal regulations or the General Rules for Oregon Medical

Assistance Programs may be granted to a CMHP for a period of up to one year in the following manner:

(1) The CMHP shall submit to the MHDDSD Title XIX Section a written request which includes:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed; and

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(2) The Assistant Administrator of the Office of Finance shall approve or deny the request for variance in writing.

(3) The MHDDSD Title XIX Section shall notify the Provider of the decision. MHDDSD shall give notice in writing within 30 days of receipt of the request.

(4) Appeal of the denial of a variance request shall be to the Administrator of MHDDSD, whose decision shall be final.

(5) All variances must be reapplied for annually.

Stat. Auth.: ORS 414.085, 430.041 & 430.640(1)(h)
Stats. Implemented: ORS 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98; MHD 11-2000, f. 8-30-00, cert. ef. 9-18-00

309-016-0430
Confidentiality of Records Requirements

(1) Providers shall keep all client records confidential in accordance with 42 CFR, Part 431, Subpart F and 42 CFR Part 2, ORS 179.505 and other applicable state or federal laws.

(2) Within 10 days of a request, providers shall make pertinent clinical and financial eligibility information concerning a client available to other service providers responsible for the client's care, consistent with ORS 179.505 and any other state statutes and federal laws and regulations concerning confidentiality.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0440
Provider Appeals Process

The Oregon Attorney General's Uniform and Model Rules of Procedure under the Administrative Procedures Act apply to provider appeals (OAR 137-003-0001 through 137-003-0092 and 137-004-0010).

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

309-016-0450
Provider Appeals — Appeal of Payment/Sanction Decisions

A provider may appeal certain decisions affecting the provider made by MHDDSD by requesting an administrative review, or a contested case hearing. Providers may appeal:

(1) A denial of or limitation of payment allowed for services or items provided;

(2) Sanctions imposed, or intended to be imposed, by MHDDSD; or

(3) Overpayment determinations.

Stat. Auth.: ORS 414.640(2) & 430.041
Stats. Implemented: ORS 414.640(2) & 430.021(2)
Hist.: MHD 6-1997(Temp), f. & cert. ef. 10-1-97; MHD 2-1998, f. & cert. ef. 3-27-98

DIVISION 31

PROGRAMS FOR MENTAL OR EMOTIONAL DISTURBANCES

Hospital Programs

309-031-0010
Forensic Psychiatric Services

(1) Purpose. This rule prescribes procedures for the assignment to state institutions of persons committed to the Mental Health and Developmental Disability Services Division by a court of criminal jurisdiction and persons ordered to a state institution by the Psychiatric Security Review Board. This rule also designates the state institution to receive other dangerous persons in certain instances.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 161.390, 179.040, and 430.041 and carries out the provisions of ORS 161.295 through 161.370, 161.725 to 161.735, 426.005 to 426.680, 427.175 and 427.180.

(3) Definitions. As used in this rule:

(a) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(b) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(c) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(d) "Psychiatric Security Review Board" is the Board created by ORS 161.385.

(e) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(f) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(g) "Superintendent" means the executive head of the state institution as listed in subsection (3)(f) of this rule.

(4) Designation of State Institution for Admission of Persons Under Jurisdiction of Court or Psychiatric Security Review Board:

(a) If a court orders a person committed to a state institution for an evaluation under ORS 161.365 to determine a defendant's fitness to proceed to trial, under ORS 161.315 to determine a defendant's criminal responsibility, or under ORS 161.725 to determine if a defendant is a habitual criminal, the person will be admitted to the Forensic Psychiatric Service of Oregon State Hospital according to conditions set forth in subsection (b) of this section, unless otherwise ordered by the Administrator;

(b) The Clinical Director of the Forensic Psychiatric Service may, upon finding that requests for admission to the Service pursuant to subsection (a) of this section are sufficient in number to require the establishment of a waiting list to govern admissions, establish a waiting list based on such factors as:

(A) Severity of the mental disorder;

(B) Degree to which the person presents an immediate and serious danger to others;

(C) Adequacy of the facility having custody to continue care and custody of the person; and

(D) Sequence in which the order or request for admission was received by the Forensic Psychiatric Service.

(c) If a court orders a person committed to a state institution after being found unfit to proceed with trial under ORS 161.370, or if a court or the Psychiatric Security Review Board orders a person committed to a state institution under ORS 161.336, 161.341, or 161.346, the person shall be admitted to the Forensic Psychiatric Service of Oregon State Hospital, unless otherwise ordered by the Administrator.

(5) Interinstitutional Transfers:

(a) If, in the opinion of the Superintendent of Oregon State Hospital or his designee, it is deemed to be required by the medical needs of the person or for the safety and welfare of the person or the safety of others that a patient of the Forensic Psychiatric Service be transferred within Oregon State Hospital, or to Dammasch State Hospital, Eastern Oregon Hospital and Training Center, or Fairview Training Center, the superintendent shall initiate a request for transfer on forms prescribed by the Division and, upon approval by the superintendent of the receiving institution, arrange for transfer. A patient of the Forensic Psychiatric Service may request such a transfer through a written request to the Superintendent of Oregon State Hospital. Transfers made to the Mental Retardation Section of Eastern Oregon Hospital and Training Center or Fairview Training Center shall comply with the eligibility requirements outlined in OAR 309-042-0000 (Admission and Release of Residents), as determined by the Diagnosis and Evaluation Service of the Mental Health and Developmental Disability Services Division;

(b) If, in the opinion of the superintendent of a state institution, it is deemed to be required by the medical needs of the person or for the safety and welfare of the person or the safety of others that a patient or resident be transferred to the Forensic Psychiatric Service, the superintendent shall initiate a request for transfer on forms prescribed by the Division and, upon approval by the Superintendent of Oregon State Hospital, arrange for transfer;

(c) If a request for transfer to or transfer from the Forensic Psychiatric Service of Oregon State Hospital is rejected by the receiv-

ing state institution, the referring institution may request the Administrator to convene the Interinstitutional Disposition Board to determine the placement consistent with the person's needs and the safety of others. The Board shall be convened as expeditiously as possible but in no case later than two weeks after such request. The decision of the chairperson shall be final;

(d) In all cases, the patient or resident shall be informed in writing of the impending transfer or rejection of the transfer request and shall be given an opportunity to request a hearing. Within seven days after a patient or resident signs a request for hearing, a hearing shall be held before the Interinstitutional Disposition Board to determine whether the patient or resident shall be transferred. The patient or resident may be transferred on a emergency basis pending the decision of the Board for a period not to exceed 15 days;

(e) The Interinstitutional Disposition Board shall not consider the request for transfer or other written evidence or oral statements unless the patient or resident has the opportunity to cross-examine the person making the statement. At the hearing before the Board, the patient or resident shall have the right to present evidence, to cross-examine all witnesses, and to be represented by an attorney upon request. These rights shall only be denied when good cause is shown;

(f) The patient or resident shall have the right to be present at the Interinstitutional Disposition Board hearing on request, except when the Board finds that the testimony of the treating physician or any other witness in the presence of the patient or resident would be damaging to the future treatment and care of the patient or resident. In that instance, the testimony and cross-examination of those witnesses shall be conducted out of the presence of the patient or resident;

(g) Based upon the testimony given before the Interinstitutional Disposition Board, the Administrator of the Division or the Administrator's designee shall determine the best placement for the patient or resident and issue a written order directing that the patient or resident be transferred or that the transfer be denied. The order shall contain a statement of the facts upon which the order is based.

(6) Interinstitutional Disposition Board:

(a) The Interinstitutional Disposition Board is composed of the following representatives:

(A) The Administrator of the Division or the Administrator's designee, who shall serve as chairperson;

(B) The Superintendent of Oregon State Hospital or alternate;

(C) The Superintendent of Dammasch State Hospital or alternate;

(D) The Superintendent of Eastern Oregon Hospital and Training Center or alternate; and

(E) The Superintendent of Fairview Training Center or alternate.

(b) The Administrator may invite such other persons to sit with the Board as the Administrator believes may be helpful in reaching a decision;

(c) The Administrator shall inform all members of the Interinstitutional Disposition Board of the standards for confidentiality of records in ORS 179.505, 192.500, and **42 CFR Part 2**, as well as prescribed penalties for failure to comply with these standards.

(7) Release of Patient or Resident. A patient or resident who is under a court having criminal jurisdiction, the Corrections Division of the Department of Human Services, or the Psychiatric Security Review Board will not be released or otherwise discharged from the custody of the Mental Health and Developmental Disability Services Division without the specific approval of the appropriate legal authority. This approval will be documented in the patient's or resident's clinical record.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 161, 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 38, f. 4-5-76, ef. 4-26-76, MHD 7-1978, f. & ef. 8-30-78; MHD 13-1982, f. & ef. 7-2-82

Admission and Discharge of Mentally Ill Persons

309-031-0200
Purpose and Statutory Authority

(1) Purpose, Summary, and Scope. These rules prescribe criteria and procedures for admission and discharge of mentally ill persons at state or other inpatient psychiatric hospitals for which the Division provides Medicaid reimbursement. The purpose of these rules is to define the appropriate use of these psychiatric hospitals and to encourage use of community services.

(2) The criteria limit hospital admissions to state or other inpatient psychiatric hospitals to adults with severe mental disorders who need hospital care or treatment. Minors are prohibited admission to adult wards. The procedures provide that persons be admitted or discharged after consultation with the responsible community mental health program.

(3) The criteria limit hospital admissions to child and adolescent treatment programs in state or other inpatient psychiatric hospitals to those children and adolescents most in need. The procedures provide that admissions for children and adolescents be coordinated through the local community coordinating committee in the child's or adolescent's county of residence.

(4) The scope of these rules is limited to persons civilly committed or voluntarily admitted. When a hospital is overcrowded, voluntary admissions may be curtailed.

(5) Statutory Authority. These rules are authorized by ORS 430.041, and 179.040, 426.220, and 430.630(1) and carry out the policies of ORS 40.610 and the provisions of ORS 179.321(1), 179.325, 179.360(1), 179.475, 419.511, 426.005 through 426.070, 426.130(3), 426.175 through 426.220, 426.300 through 426.309, 430.021, and 430.620 through 430.670.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

309-031-0205
Definitions

As used in these rules:

(1) "Admission" means accepting a person for treatment of a mental illness by a state or other inpatient psychiatric hospital on a voluntary basis (ORS 426.217 or 426.220) or civil commitment (ORS 426.005 through 426.217).

(2) "Commitment" means the involuntary admission of a person to a state or other inpatient psychiatric hospital under warrant of detention (ORS 426.070), civil commitment (ORS 426.130(3)), two-physician hold (ORS 426.175), emergency commitment (ORS 426.180 to 426.210), or peace-officer hold (ORS 426.215).

(3) "Community Coordinating Committee" means a committee composed of representatives from the local community mental health program, Children's Services Division, Juvenile Court, local education district, and a representative of Oregon State Hospital's Child and Adolescent Treatment Program. The committee carries out the intake function to assure the need for hospitalization.

(4) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(5) "Community Outreach Team" means a component of Oregon State Hospital's Child and Adolescent Treatment Program responsible for coordinating all community screenings, crisis and regular admissions, and discharge and follow-up activities.

(6) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(7) "DSM-III-R" means **Diagnostic and Statistical Manual of Mental Disorders, Third Edition, American Psychiatric Association, 1987.**

(8) "Hospital-Community Linkage Agreement" means the written agreement between community mental health programs and a state psychiatric hospital concerning the policies and procedures to be followed when a patient is admitted and discharged. (See ORS 430.630(6) and OAR 309-014-0035(2)(c)).

(9) "Other Inpatient Psychiatric Hospital" means those parts of a licensed psychiatric hospital receiving Medicaid reimbursement for eligible patients through the Mental Health and Developmental Disability Services Division.

(10) "Parent" means a custodial parent, the adult next of kin, or the legal guardian of a minor. (See ORS 426.220.)

(11) "Patient" means a child, adolescent or adult admitted to a state or other inpatient psychiatric hospital.

(12) "Program Bed Capacity" means the greatest number of patients at a state psychiatric hospital that can be managed in a safe, therapeutic environment.

(13) "Program Office" means the Office of Programs for Mental or Emotional Disturbances of the Mental Health and Developmental Disability Services Division.

(14) "Psychiatric Emergency" means an imminent threat to life or of serious bodily injury to self or others resulting from severe mental disorder.

(15) "Psychotic" means a gross impairment of reality testing, as defined in the **DSM-III-R Glossary**. Persons with a psychotic disorder may "hear voices," talk incoherently or illogically, strongly hold irrational beliefs, fail to react to the external environment, or experience unwarranted feelings of deep depression, extreme elation or intense anxiety. Their thinking is so disordered that they have substantially lost touch with reality.

(16) "Resident" means the resident of a county in which the person maintains a current mailing address or, if the person does not maintain a current mailing address within the state, the county in which the person is found, or the county in which a court committed mentally ill person has been conditionally released. ORS 430.630(4)(a).

(17) "Responsible Community Mental Health Program" means the community mental health program (CMHP) that serves the county where the person is a resident.

(18) "Severe Mental Disorder" means psychotic disorder or other mental disorder of comparable severity. Any severe mental disorder may exist in stages and forms manageable in the community, and may be either active or in remission.

(19) "State Psychiatric Hospital" means Dammasch State Hospital, Eastern Oregon Psychiatric Center, or General Psychiatric Services, Geropsychiatric Treatment Program and the Child and Adolescent Treatment Program at Oregon State Hospital.

(20) "Superintendent" means the chief executive officer of the state or other inpatient psychiatric hospital, or that officer's designee. If the superintendent is not a physician licensed by the State Board of Medical Examiners, the chief medical officer shall assume the duties prescribed in these rules. ORS 179.360(1)(f) and 426.020.

[Publication: Publications referenced are available from the agency.]

Stat. Auth.: ORS 179, 414, 419, 426 & 430

Stats. Implemented:

Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

309-031-0210

Criteria for Admission to and Discharge From State or Other Adult Inpatient Psychiatric Hospitals

(1) Admission Criteria:

(a) Mental disorder. All admissions, voluntary and civilly committed, shall be limited to adults whose mental disorder is severe; and

(b) Need specialized care and/or treatment available in a state or other inpatient psychiatric hospital and not otherwise available to the patient in a community program. A patient needs hospital care and/or treatment if failure to receive it would result in serious harm.

(2) Discharge Criteria:

(a) Mental disorder. The superintendent or designee shall discharge any patient (whether voluntarily admitted or civilly committed) whose mental disorder:

(A) Is no longer present, in remission; or

(B) Can receive appropriate care and/or treatment which is available to the patient in a community program.

(b) However, a patient whose disorder is in remission should not be released if continued hospital care or treatment is needed to help the patient remain in remission for a reasonable time after release;

(c) Medical Judgment. The findings of severe mental disorder required by sections (1) and (2) of this rule, shall be according to reasonable medical judgment.

Stat. Auth.: ORS 179, 414, 419, 426 & 430

Stats. Implemented:

Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

309-031-0215

Procedures for Admission to and Discharge From State or Other Adult Inpatient Psychiatric Hospitals

(1) Screening. The responsible community mental health program (CMHP) shall, if possible, screen and refer persons whose admission to a state or other inpatient psychiatric hospital is sought. The purpose of this screening is to determine the availability of appropriate care or treatment in the community. For state hospitals, hospital-community linkage agreements shall specify the procedures for screening. The CMHP shall communicate the results of screening by telephone.

(2) Scheduling. In order to provide a comprehensive evaluation in a state hospital, admission should occur between 8:30 a.m. and 4 p.m., Mondays through Fridays except holidays. The responsible CMHP should telephone the hospital to make appointments for these evaluations and should be available for telephone consultation.

(3) Temporary Admissions. In exceptional situations, persons who meet the admission criteria and who need immediate hospitalization may be temporarily admitted to a state hospital at any time. Exceptional situations include but are not restricted to persons:

(a) For whom screening or scheduling by the responsible CMHP is not feasible;

(b) Who pose a psychiatric emergency;

(c) Who present themselves at the hospital having travelled long distances;

(d) Who have been committed by warrant of detention, two-physician hold, emergency commitment, or peace-officer hold;

(e) For whom team evaluation cannot be scheduled; or

(f) Whom a private physician has referred;

(g) The superintendent or designee shall notify the responsible CMHP of temporary admissions. This notice shall be given either immediately, if the CMHP is open or has a 24-hour crisis response, or at the beginning of the next CMHP workday. The hospital team shall re-evaluate each temporary admission after consultation with the CMHP, during scheduled hours. This consultation shall determine whether appropriate care or treatment is available in the community. No temporary admission shall extend beyond the next scheduled admission day.

(4) Authority. The superintendent or designee has the final authority on the decision to admit and discharge voluntary patients and to discharge civilly committed patients. The Administrator of the Division has authority to assign civilly committed patients to the appropriate facility, unless the Administrator has delegated this authority to a county. ORS 426.060(2) through 426.060(4).

(5) Records. The superintendent or designee shall document in the patient's clinical record:

(a) Those aspects of the history and/or examination used in arriving at the conclusions that a patient is severely mentally disordered and needs hospital care or treatment, or that the patient poses a psychiatric emergency;

(b) Sufficient medical orders to provide for the initial care, safety, and treatment of the patient;

(c) The procedures by which the patient was admitted or discharged;

(d) The reasons for discharge; and

(e) The recommendations of the CMHP, the hospital's action in response, and the hospital's reasons if these recommendations have not been followed.

(6) Notice. When a patient is admitted or discharged, the superintendent or designee shall promptly notify the responsible CMHP. For civilly committed patients, the court shall also be notified. If the patient has had no responsible CMHP or if the responsible CMHP is unknown, the superintendent or designee shall determine the patient's county of residence, in order to determine which CMHP is responsible for the patient. See the definitions of "resident" and "responsible CMHP," OAR 309-031-0025. The superintendent or designee shall inform the patient of the CMHP responsible for him or her.

(7) Referral. If admission is denied, the superintendent or designee shall promptly notify the responsible CMHP and, for civilly committed patients the court, and for patients referred by private physicians, the physician. The superintendent or designee shall refer the person to appropriate community care including crisis respite services, and should assist the person in obtaining alternative care.

(8) Periodic Review. Patients who remain in a state or other inpatient psychiatric hospital after 15 days shall be reviewed by staff of the responsible CMHP. The purpose of this review is to determine the availability of appropriate resources for care or treatment in the community. For state psychiatric hospitals, hospital-community linkage agreements shall specify the procedure for review. The CMHP shall, directly or by telephone, notify the hospital staff of the recommendations resulting from this review. The recommendation shall be either:

(a) That appropriate resources do not exist in the community, and that the CMHP recommends continued hospitalization. A new review shall be conducted within 60 days. Hospital-community linkage agreements may specify more frequent review; or

(b) That appropriate resources do exist in the community. The CMHP, with the cooperation of the hospital staff, shall develop a discharge plan for the patient.

(9) Utilization Review. Each state psychiatric hospital shall systematically review admissions and discharges at that hospital. A plan for this utilization review shall be established by the superintendent or designee, submitted to the Program Office within 30 days of adoption of this rule, and approved by the Program Office. This review will monitor the number and appropriateness of temporary and regular admissions, the length of stay, discharges, and the quality of care and treatment provided.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 24-1982, f. 10-13-82, ef. 11-15-82; MHD 7-1987, f. & ef. 12-30-87

309-031-0220
Additional Procedures for Voluntary Admission to and Discharge From State or Other Adult Inpatient Psychiatric Hospitals

In addition to the criteria of OAR 309-031-0210 and the procedures of OAR 309-031-0215, the following procedures shall apply to voluntary admission and discharge:

(1) Voluntary Admission Procedure. Persons who apply for voluntary admission may be admitted to a state or other inpatient psychiatric hospital only when the superintendent or designee has:

(a) Informed the person regarding the procedures for voluntary admission and discharge, including the 72-hour hold after withdrawal of consent under section (3) of this rule; and

(b) Witnessed the signature on a form approved by the Division.

(2) Discharge at the Patient's Request. Patients voluntarily admitted and not involuntarily committed to the Mental Health and Developmental Disability Services Division and assigned to a state or other psychiatric hospital shall be discharged within 72 hours of receipt of written notice of a desire to be discharged, pursuant to ORS 426.220(1), as follows:

(a) All patients shall be released within 72 hours of receipt of written notice from the patient;

(b) Written notice under this section may be submitted to the superintendent or designee, the patient's attending physician, or the hospital staff that provides immediate care and supervision. If a patient gives oral notice, the staff shall assist the patient in giving written notice;

(c) If the medical staff believes that discharge would be detrimental to the health and safety of the patient or others, but the patient does not meet the criteria for involuntary commitment, OAR 309-031-0210, the patient shall be discharged against medical advice. The patient shall be informed of this medical opinion;

(d) If the medical staff believes that the patient meets the criteria for involuntary commitment, the staff shall so inform the patient. The staff may initiate an involuntary commitment proceeding;

(e) An adult seeking voluntary admission to a state psychiatric hospital may be required, as a condition of admission, to waive his or her right to terminate the voluntary admission for a period not to exceed 30 days. The admitting medical staff may require this waiver if they believe that the person's mental disorder could not otherwise be successfully treated.

(3) Transfer to Another Medical Facility. If a patient voluntarily admitted develops a surgical or medical condition that requires transfer to another medical facility, that patient may be discharged from the state or other inpatient psychiatric hospital at the time of transfer.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 50(Temp), f. & ef. 12-21-77; MHD 6-1978, f. & ef. 3-20-78; MHD 24-1982, f. 10-13-82, ef. 11-15-82, Renumbered from 309-031-0020; MHD 7-1987, f. & ef. 12-30-87

309-031-0250
Program Bed Capacity

(1) In order to prevent unsafe or untherapeutic conditions due to overcrowding, the Program Office, in consultation with the superintendent or designee, shall establish the Program Bed Capacity for each state psychiatric hospital. The Program Bed Capacity shall depend on such factors as budgeted staffing levels, licensed bed capacity, and ward geography.

(2) Whenever the Program Bed Capacity is exceeded, the Superintendent or designee shall take immediate steps to reduce the hospital population. These steps may include denying voluntary admissions. Whatever the hospital population, a person who poses a psychiatric emergency shall have high priority for admission or retention.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 7-1987, f. & ef. 12-30-87

309-031-0255
Variances

A variance from these rules may be granted to a Superintendent of a state or other inpatient psychiatric hospital. A variance may be requested on a case-by-case basis, or may exempt a state or other psychiatric hospital from a general rule or rules and substitute an alternative practice.

(1) A superintendent of a state or other psychiatric hospital requesting a variance shall submit, in writing, to the Office for Mental or Emotional Disturbances:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) The duration that the alternative practice will remain in effect.

(2) The Assistant Administrator of the Office for Mental or Emotional Disturbances shall approve or deny the request for variance in writing.

(3) The Assistant Administrator of the Office for Mental or Emotional Disturbances shall notify the Superintendent of the decision. Notice shall be given, in writing, within 30 days of receipt of the request by the Office for Mental or Emotional Disturbances.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Mental Health and Developmental Disability Services Division, whose decision shall be final.

Stat. Auth.: ORS 179, 414, 419, 426 & 430
Stats. Implemented:
Hist.: MHD 7-1987, f. & ef. 12-30-87

DIVISION 32

COMMUNITY TREATMENT AND SUPPORT SERVICES

309-032-0001
Standards for Inpatient Psychiatric Services

(1) Purpose. This rule prescribes standards for programs which, as alternatives to state hospitalization, provide inpatient psychiatric services as part of a community mental health program.

(2) Statutory Authority and Procedures. This rule carries out and is authorized by ORS 430.610 to 430.670.

(3) Application for Approval. A community mental health program may be approved by the Division to provide, as alternatives to state hospitalization, inpatient psychiatric services only upon its written application and in accordance with OAR 309-012-0010 (Letters of Approval).

(4) Standards for Approval. In order to be approved by the Division for funding of inpatient psychiatric services, a community mental health program shall:

(a) Have an ongoing utilization review system which shall be applied to patients receiving services under this rule;

(b) Have a contract with the community hospital providing the inpatient service. The contract shall be approved by the appropriate regional Assistant Administrator of the Division and shall at least specify:

(A) The procedure by which the community mental health program will pay for hospital services;

(B) The criteria for a patient's eligibility to participate in the program;

(C) The method by which the community mental health program director approves a patient for participation in the program;

(D) The types of services the community hospital will provide;

(E) That charges by the community hospital under the contract shall be the same as charges by the community hospital to private patients;

(F) The total maximum amount of payments by the community mental health program to the community hospital under the contract;

(G) The community hospital's utilization review system applicable to patients in the program.

(5) Patient Eligibility:

(a) Eligibility criteria. To be eligible for inpatient services under this rule a patient shall:

(A) Be in need of 24-hour-a-day medical supervision, treatment and care;

(B) Be at a substantial risk of requiring hospitalization in a state mental hospital;

(C) Have a psychiatric diagnosis identified in the "**Diagnosis and Statistical Manual of Mental Disorders**";

(D) Require 12 days or less hospitalization; and

(E) Be determined by the community hospital with the approval of the community mental health program director or his designee not to have financial resources available to pay for hospitalization. To determine a patient's financial resources, the community mental health program director and the community hospital shall consider:

(i) The patient's gross income;

(ii) The number of the patient's dependents;

(iii) The patient's employment status;

(iv) The patient's debts;

(v) The degree of the patient's disability;

(vi) Third-party resources available for the benefit of the patient, including medicare, medicaid or private insurance.

(b) Funds provided by the Division to a county may not be used to purchase community inpatient services under this rule unless, and only to the extent that, other resources, including personal resources of the patient, private insurance, and medicare, are insufficient to pay the costs of the inpatient services. However, funds provided by the Division may not be used for a patient in whose behalf payments are made under Title XIX of the Social Security Act;

(c) No funds provided by the Division to a county for a program approved under this rule may be used to pay the costs of holding an allegedly mentally ill person against whom civil commitment proceedings have been instituted;

(d) Funds provided by the Division to a county for a program approved under this rule may be used to pay the costs of up to seven days of hospitalization, except that an additional five days of hospitalization may be paid for under this rule if a utilization review committee determines additional hospitalization is needed. If more than 12 days hospitalization are necessary, a patient who is certified for services under this rule may be transferred to the appropriate state hospital.

(6) State Financial Participation:

(a) The Division shall reimburse a county whose community mental health program has been approved under this rule for community inpatient services up to the maximum amount agreed upon with the county as stated in the contract between the Division and the county;

(b) Certification of Eligibility. The community mental health program director or his designee shall certify which patients are eligible for community inpatient services under this rule.

[Publication: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 33, f. 9-5-75, ef. 9-26-75

Sexual Offender Treatment Program

309-032-0070
Purpose and Statutory Authority

(1) Purpose. These rules prescribe the standards of the Mental Health and Developmental Disability Services Division for the operation of a community mental health program utilizing medication for the treatment of sexual deviation (hereinafter "the program").

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 135.930 through 135.950.

Stat. Auth.: ORS 135 & 430

Stats. Implemented:

Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0075
Definitions

As used in these rules:

(1) "Adjunctive Therapy" means any course of education and/or treatment deemed necessary by program staff for successful completion of the program by a program client. The need for adjunctive therapy may be either identified during the evaluation of an applicant for the program or while a client is participating in the program.

(2) "Applicant" means a person who has given informed consent to be evaluated for the program.

(3) "Client" means a person receiving services under these rules.

(4) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other develop-mental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(5) "Department of Corrections" means the Department of Corrections of the Department of Human Services, or its designee(s). Designees of the Department of Corrections may be a county operated corrections program, or any other person or agency designated by the Administrator of the Department of Corrections.

(6) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(7) "Evaluation" means an assessment of an individual to determine the existence of a sexual deviation, whether the individual is medically suitable and psychologically suitable to participate in the program, and to document the need for adjunctive therapy should the applicant be accepted for the program.

(8) "Forcible Compulsion" means physical force that overcomes earnest resistance; or a threat, express or implied, that places a person in fear of immediate or future death or physical injury to self or another person, or in fear that the person or another person will immediately or in the future be kidnapped (ORS 163.305(2)).

(9) "Informed Consent" means the applicant has been informed by the treating physician about the program, possible side effects of medications or other treatment, possible benefits from participation in the program, procedures for determining if the applicant is medically and psychologically suitable for the program, and program rules the applicant agrees to follow if accepted for the program. Informed consent exists when the applicant signs a program application that documents that the above information has been explained to the applicant, the applicant has had an opportunity to ask questions about the program, and the applicant requests evaluation for the program.

(10) "Medically Suitable" means the applicant has been examined by a physician licensed to practice medicine in the State of Oregon and no present medical condition has been found that would prohibit the applicant from receiving treatment in the program. Documentation that the client is medically suitable will be included in the applicant's file before treatment begins.

(11) "Medication" means a drug prescribed by a program physician as part of a treatment program designed to eliminate deviant sexual behavior.

(12) "Board of Parole and Post-Prison Supervision" means the State Board of Parole created by ORS 144.005 which may authorize any inmate, who is committed to the legal and physical custody of the Department of Corrections, to go upon parole.

(13) "Program Staff" means the program will either have or contract for staff with the following qualifications:

(a) A physician, licensed to practice medicine in the State of Oregon;

(b) A psychiatrist licensed to practice medicine in the State of Oregon or a clinical psychologist licensed to practice psychology in the State of Oregon;

(c) A mental health professional experienced in the treatment of sexual deviation;

(d) A behavioral therapist approved by the Division to use psycho-physiological instruments that measure sexual arousal including, but not limited to, the penileplethysmograph; and

(e) Other staff experienced in providing adjunctive therapy as necessary.

(14) "Psychologically Suitable" means the applicant has been assessed by a psychiatrist or licensed psychologist to determine the existence of a sexual deviation that is treatable.

(15) "Treatment Plan" means the prescribed course of activities of each client in the program. At a minimum, the treatment plans shall include:

(a) The specific treatment to be administered and the prescribed dates and times of treatment;

(b) The prescribed course of any adjunctive therapy the client will follow; and

(c) Evidence that the client has given informed consent to participate in the treatment plan.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0080
Program Approval

A program for the treatment of sexual deviation shall:

(1) Meet the standards set forth in these rules, those provisions of OAR 309-014-0000 through 309-014-0040 that are applicable, and any other Division administrative rules applicable to the program. A letter of approval issued to the program under OAR 309-012-0010 shall be effective for two years from the date of issue and may be renewed or revoked by the Division as set forth in OAR 309-012-0010; and

(2) Submit to the Division a plan for program organization and administration. The plan will include:

(a) An organization chart showing the lines of authority for the program including any parts of the program that are subcontracted by the community mental health program;

(b) A description of which program staff will provide the functions as described in OAR 309-032-0085 through 309-032-0100.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0085
Eligibility for Treatment

To be eligible for treatment by the program, the person must reside or intend to reside in a county having a program and must meet one of the following eligibility criteria:

(1) The person has been convicted of committing, or attempting to commit, a sexual crime involving forcible compulsion, is not appealing the conviction, or the conviction has been sustained upon appeal, and the Court makes participation in the program a condition of probation following a court ordered evaluation by the Division; or

(2) The Board of Parole and Post-Prison Supervision orders an evaluation by the Division of the person currently imprisoned for a sexual crime involving forcible compulsion and the Division finds the person to be medically suitable and likely to benefit from the program; or

(3) The person is currently on probation or parole, was convicted of a sexual crime, and voluntarily applies to the program for evaluation; or

(4) The person has not been convicted of a sexual crime and voluntarily applies to the program for evaluation.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0090
Eligibility for Acceptance into the Program

To be accepted as a client in the program, the individual must:

(1) Meet the eligibility criteria for evaluation as outlined in OAR 309-032-0085;

(2) Give informed consent to participate in the program; and

(3) Be evaluated by the Division or it's designee and be found to be medically and psychologically suitable for the program.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0095
Evaluation for the Program

(1) Initial Interview. Upon receipt of a request for an evaluation program staff will interview the person. At a minimum, the staff person will:

(a) Assess whether the person has the proper legal status to be eligible for evaluation;

(b) Assess whether the person resides or intends to reside in the county where the program is located;

(c) Explain program policies and procedures;

(d) Obtain intake information;

(e) Obtain signed release of information forms, if necessary;

(f) Obtain a signed fee agreement, if appropriate;

(g) Obtain a signed post-treatment assessment agreement; and

(h) Arrange for a medical and psychological evaluation to complete the evaluation process.

(2) Medical Evaluation. Program staff will insure that each applicant receives a medical examination before acceptance in the program. The evaluation will include:

(a) Lab testing to determine the pre-treatment serum testosterone level, sperm count, and sperm morphology;

(b) Other laboratory tests deemed necessary by the examining physician;

(c) Screening for a history of high blood pressure, diabetes, migraine headaches, gall bladder disease, and any physical signs of alcoholism, or other substance abuse; and

(d) A written report from the examining physician indicating the applicant is or is not medically suitable for the program.

(3) Psychological Evaluation. If the applicant is found to be medically suitable for the program, he will be evaluated by a psychiatrist or a licensed psychologist to determine if he is psychologically suitable for the program. At a minimum, the evaluation will include:

(a) A complete clinical interview including a detailed sexual history, any indications of alcoholism or other substance abuse, and an assessment of the client's willingness and ability to participate in and benefit from treatment;

(b) An arousal assessment, utilizing the penileplethysmograph, which may be administered by a behavioral therapist;

(c) Psychological testing, if necessary;

(d) Recommendations for adjunctive therapy and any additional requirements thought necessary for the client to successfully complete the program; and

(e) A written report indicating whether the applicant is or is not psychologically suitable for the program including the existence of any conditions which might prohibit the applicant from successfully completing the program.

(4) Program staff will convene a pre-treatment client staffing. The pre-treatment staffing will:

(a) Inform the client of the results of the evaluation;

(b) Obtain a signed release of information form for each person/agency providing service to the client;

(c) Develop an initial treatment plan for the client to be signed by the client; and

(d) Review program policies and procedures to insure the client understands what is necessary for successful completion of the program and under what conditions the client may be terminated from the program.

(5) Following the pre-treatment staffing, the physician, together with other program staff as appropriate, will obtain a signed informed consent from the client and document it in the clinical record.

(6) If the Court or Board of Parole and Post-Prison Supervision has ordered the evaluation, the results and recommendations from the evaluation will be forwarded to them:

(a) At a minimum the report to the Court or Board of Parole and Post-Prison Supervision will include:

(A) A statement by the physician that the applicant is or is not medically suitable for the program;

(B) A statement that the applicant is or is not psychologically suitable for the program; and

(C) A recommendation that the applicant should or should not be allowed to participate in the program.

(b) If the recommendation is that the applicant should be allowed to participate in the program, the report will also include:

(A) A specific medication schedule indicating the times and places for treatment; and

(B) A schedule for adjunctive therapy.

(c) The program may recommend that additional requirements be imposed on the applicant. They may include, but are not limited to requirements that the applicant:

(A) Participate in alcoholism or other substance abuse treatment;

(B) Submit to urine surveillance;

(C) Take monitored Antabuse; and/or

(D) Be restricted to a specific living arrangement or place of employment in order to reduce potential risk to the community.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0100
Client Treatment

(1) Each applicant who is recommended and accepted for treatment becomes a client of the program. Each client shall be assigned a specifically designated case manager who shall monitor and evaluate all treatment and assess the effects of treatment and client compliance.

(2) The case manager shall be responsible for maintaining a complete client file on each client. Each client file shall contain the following:

(a) Client identifying information;

(b) A copy of the informed consent document;

(c) A copy of all release of information forms signed by the client;

(d) The initial interview report;

(e) A copy of all evaluation reports and other assessments;

(f) A copy of all informed consent statements;

(g) A copy of all Court or Board of Parole and Post-Prison Supervision orders, and all other required conditions;

(h) Signed and dated notations of client participation in the program, including:

(A) All medications received or missed;

(B) All adjunctive therapy sessions attended or missed;

(C) Monthly progress notes that include an assessment of the client's progress or lack of progress toward treatment plan objectives;

(D) Any side effects of taking medications along with any recommendations or actions taken to control or eliminate those side effects; and

(E) Any client staffings held regarding the client.

(i) All post-treatment assessments; and

(j) Other information the program deems necessary or is required by other Division administrative rules.

(3) If participation in the program is a condition of parole or probation, the case manager will report to the Court, Board of Parole and Post-Prison Supervision and/or the Department of Corrections when each of the following occur:

(a) Upon acceptance of the applicant as a client in the program; and

(b) Upon request of the Court, Board of Parole and Post-Prison Supervision or the Department of Corrections for periodic reports to monitor client participation in the program; and

(c) Termination from the program.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0105
Termination from the Program

A client of the program may be terminated from the program if the client:

(1) Withdraws content for further participation in the program;

(2) Develops a medical condition that precludes further treatment;

(3) Has been determined to be psychologically unsuitable for further participation in the program;

(4) Has achieved maximum benefit from treatment;

(5) Has violated program rules;

(6) Commits a new offense, including a sexual offense, which makes the client unsuitable for community supervision;

(7) Threatens the security or safety of the program or program participants;

(8) Fails to keep scheduled appointments for medication and/or adjunctive therapy;

(9) Refuses treatment deemed necessary by program staff for a diagnosed substance abuse problem (whether the diagnosis is made before or after entry into the program); or

(10) Violates any requirements of the Court or Board of Parole and Post-Prison Supervision.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0110
Post-Treatment Follow-Up

(1) As a requirement of program participation, the client will agree to post-treatment assessments six months after the client leaves the treatment program. These assessments will include:

(a) Laboratory tests for serum testosterone level, sperm count, and sperm morphology; and

(b) Interviews which shall document:

(A) The present/absence of any deviant sexual fantasies. This will be documented through the use of the penileplethysmograph;

(B) The presence/absence of any medical side effects which could be the result of treatment;

(C) The presence/absence of any psychological side effects which could be a result of participation in the program or adjunctive therapy.

(2) The program will monitor the post-treatment activity of program clients by performing law enforcement data system (LEDS) checks on former program clients. These checks will be at six month intervals for a period of three years post treatment.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

309-032-0115
Variances

A variance from these rules may be granted to a program in the following manner:

(1) A program requesting a variance shall submit, in writing, through the Office of Programs for Mental or Emotional Disturbances:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the local mental health authority indicating its position on the proposed variance.

(2) The assistant administrator of the Office of Programs for Mental or Emotional Disturbances shall approve or deny the request for variance.

(3) The program office shall notify the community mental health program of the decision. The community mental health program will forward the decision and reasons therefor to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the program or administrative office with a copy to other relevant sections of the Division.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division, whose decision shall be final.

(5) A variance granted by the Division shall be attached to, and become part of, the contract for that year.

Stat. Auth.: ORS 135 & 430
Stats. Implemented:
Hist.: MHD 6-1984(Temp), f. & ef. 9-19-84; MHD 8-1984, f. & ef. 11-26-84

Standards for Community Mental Health Services for the Homeless Mentally Ill

309-032-0175
Purpose and Statutory Authority

(1) Purpose. These rules prescribe the standards for community-based programs that serve homeless individuals with a chronic mental illness.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 430.140 and carry out the provisions of ORS 430.610 through 430.685.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0180
Definitions

As used in these rules:

(1) "Chronically Mentally Ill Person" means a person who is 18 years of age or older and who satisfies both of the following criteria:

(a) Has been diagnosed by a psychiatrist, by a licensed clinical psychologist or by an examiner certified by the Mental Health and Developmental Disability Services Division as having chronic schizophrenia, a chronic major mood disorder, chronic paranoid

disorder (**DSM-111-R** diagnoses of 295.12, .22, .32, .40, .63, .70, .92; 296.2, .3, .4, .5, .6; 297.1, .3), or another chronic psychotic disorder other than those caused by substance abuse; and

(b) Demonstrates impaired role functioning in at least two of the following areas:

(A) Social role: an inability to function independently in the role of worker, student, or homemaker;

(B) Daily living skills: an inability to engage independently in personal care (grooming, personal hygiene, etc.) or community living activities (handling personal finances, using community resources, performing household chores, etc.); or

(c) Social acceptability: an inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or the judicial system.

(2) "Client" means a person receiving services under these rules.

(3) "Community Mental Health Program (CMHP)" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(4) "Division" means the Mental Health and Developmental Disability Services Division, of the Department of Human Services, of the State of Oregon.

(5) "Homeless Individual" means a person who has no fixed place of residence or resides in temporary housing such as a hotel or shelter.

(6) "Local Mental Health Authority" means an entity operating under an intergovernmental agreement or a direct contract with the Mental Health and Developmental Disability Services Division to administer a community mental health program in a specific geographic area of the state.

(7) "Outreach" means the delivery of mental health services, referral services and case management services in non-traditional settings, such as shelters, streets, transitional housing sites, drop-in centers or single room occupancy hotels.

(8) "Qualified Mental Health Associate" means any person delivering services under the direct supervision of a qualified mental health professional and meeting the following minimum qualifications:

(a) A bachelor's degree in a mental health related field; or

(b) A combination of at least one year's work experience and two years education, training or work experience in mental health.

(9) "Qualified Mental Health Professional" means any person meeting the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in Psychology;

(d) Graduate degree in Social Work;

(e) Graduate degree in Psychiatric Nursing and Licensed in the State of Oregon;

(f) Graduate degree in another mental health related field;

(g) Registration as an Occupational Therapist; or

(h) Graduate degree in Recreational Therapy.

[Publication: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0185
Services to be Provided

The following community mental health services for homeless individuals with a chronic mental illness shall be available:

(1) Case management to include:

(a) Identifying, screening and evaluating potential clients to determine their eligibility for services;

(b) Preparing individualized service plans meeting the record requirements of this rule for each client accepted for service. To the extent possible, the plans shall be prepared with the participation of the client and, as appropriate, significant others in the client's life. Plans shall be updated as appropriate, but not less than every three months;

(c) Assistance in applying for benefits to which the client is entitled. Staff shall routinely help clients secure resources such as Social Security benefits, General Assistance, food stamps, vocational rehabilitation, and housing assistance. When needed, staff shall accompany clients to help them apply for benefits;

(d) Provision of representative payee services in accordance with Section 1631 (a)(2) of the Social Security Act, when appropriate;

(e) Coordinating services with other agencies and resources, organizing and conducting case staffings as needed;

(f) Providing emotional support and counseling to clients throughout the provision of all other services listed in these rules; and

(g) Assuring that clients are informed about services that are available through community mental health programs.

(2) Outreach services to help clients gain access to needed services.

(3) Diagnostic services.

(4) Crisis intervention services.

(5) Purchase of temporary shelter, food, clothing, hygiene supplies and medications as may be necessary to engage a client in mental health services.

(6) Daily structure, support, supervision and skill training in shelter and other temporary residential settings. Skill training shall include household skills, money management, personal hygiene, and self-management of medications, as needed to increase independent living skills and the likelihood of securing stable housing.

(7) Referral to other agencies as appropriate for needed medication management for primary health services, hospital services and substance abuse services.

(8) Training to staff members of other agencies that provide services to homeless individuals with a chronic mental illness, including persons working in shelters, mental health clinics, and other places where homeless individuals receive services. Such training shall include training with respect to:

(a) Identifying individuals who are chronically mentally ill; and

(b) Referring individuals to services available to the mentally ill.

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0190
Client Eligibility

(1) Community mental health services for the homeless shall enroll and serve individuals who:

(a) Are homeless or subject to a significant probability of becoming homeless; and

(b) Are chronically mentally ill.

(2) Community mental health services for the homeless may also serve individuals who are believed to be eligible when insufficient information exists to clearly establish eligibility:

(a) A client's eligibility shall be determined and documented at the earliest possible date; and

(b) Individuals determined to be ineligible shall be referred to other appropriate services or agencies.

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0195
Staff Qualifications and Training Standards

(1) Staff delivering case management and outreach services to clients enrolled in a community mental health program for homeless individuals who have a chronic mental illness shall be qualified mental health professionals or qualified mental health associates and have demonstrated ability to:

(a) Identify individuals who are chronically mentally ill;

(b) Refer individuals to services available to the mentally ill including substance abuse programs, vocational rehabilitation programs, literacy programs, health programs and community mental health programs.

(2) All staff delivering community mental health services to homeless individuals with a chronic mental illness shall have training and qualifications appropriate to the services they are responsible for providing to clients. All staff shall operate under the supervision of a qualified mental health professional.

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0200
Client Rights

Programs operating under provisions of this rule shall have written procedures to assure client rights as follows:

(1) Protection of client privacy and dignity;

(2) Confidentiality of records consistent with state statutes and federal statutes and regulations;

(3) Involvement of the client in planning the service through the provision of information, presented in terms understood by the general public, which explains the following:

(a) The service to be provided;

(b) Alternative services available;

(c) Risks, if any, involved in the service as provided;

(d) The client's right to refuse the service; and

(e) The client's grievance procedure.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0205
Record Requirements

(1) A record shall be maintained for each client who enrolled under this rule. The record shall contain:

(a) A description of the client;

(b) An assessment of the client's needs including strengths, weaknesses, presenting problem, and diagnosis;

(c) A service plan defining service objectives, proposed interventions, and assignment of staff responsibility;

(d) Progress notes that provide an on-going account of client contacts, a description of service delivered, and monitoring of service objectives; and

(e) A termination summary describing reasons for the client no longer being involved in service.

(2) A record shall be maintained for individuals served but not yet enrolled under the provisions of OAR 309-032-0190(2) of this rule. The record shall contain:

(a) A description of the client;

(b) A preliminary assessment of the client's need based on available information; and

(c) A record of where and when contacts with the client were made and the outcome of these contacts.

(3) Records shall be confidential in accordance with ORS 179.505, **45 CFR Part 2**, Mental Health and Developmental Disability Services Division administrative rules pertaining to client records, and the current edition of the **Mental Health and Developmental Disability Services Division Handbook on Confidentiality**.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

309-032-0210
Variances

A variance from these rules may be granted to a service provider in the following manner:

(1) A written request shall be submitted through the community mental health program to the Program Office for Mental or Emotional Disturbances stating:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance, if appropriate, with the section of the rule from which the variance is sought; and

(e) In writing, a signed document from the local mental health authority indicating its position on the proposed variance.

(2) The Assistant Administrator of the Program Office for Mental or Emotional Disturbances shall approve or deny the request for variance.

(3) The program Office for Mental or Emotional Disturbances shall notify the community mental health program of the decision. The community mental health program will forward the decision and reasons therefor to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the Program Office for Mental or Emotional Disturbances with a copy to other relevant sections of the Division.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division, whose decision shall be final.

(5) A variance granted by the Division shall be attached to, and become part of, the contract for that year.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 1-1988(Temp), f. & cert. ef. 2-16-88; MHD 4-1988, f. & cert. ef. 4-29-88

Standards for Supported Employment Services

309-032-0220
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for operation of supported employment services approved by the Mental Health and Developmental Disability Services Division.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 430.1240 and carry out provisions of ORS 430.610 through 430.685.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

309-032-0225
Definitions

(1) "Chronically Mentally Ill Person" means a person who is 18 years of age or older and who satisfies both of the following criteria:

(a) Severe mental disorder as identified by a psychiatrist, by a licensed clinical psychologist or by a non-medical examiner certified by the Mental Health and Developmental Disability Services Division. Must be diagnosed as having a Schizophrenic, Major Affective or Paranoid Disorder (**DSM-III-R** diagnosis of 295.1, .2, .3, .4, .6, .7, .9; 296.2, .3, .4, .5, .6; or 297.1, .3), or another severe mental disorder with a documented history of persistent psychotic symptoms other than those caused by substance abuse; and

(b) Impaired role functioning, consisting of at least two of the following:

(A) Social role: An inability to function independently in the role of worker, student, or homemaker;

(B) Daily living skills: An inability to engage independently in personal care (grooming, personal hygiene, etc.) or community living activities (handling personal finances, using community resources, performing household chores, etc.); or

(C) Social acceptability: An inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

(2) "Client" means a person receiving services under these rules.

(3) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(4) "Community Support Unit" means the organization of community support services in a community mental health program.

(5) " Competitive Work" work that is performed on a full-time basis or on a part-time basis averaging at least 20 hours per week for each pay period and for which an individual is compensated in accordance with the Fair Labor Standards Act.

(6) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(7) "DSM III-R" means **"Diagnostic and Statistical Manual of Mental Disorders," Third Edition Revised, American Psychiatric Association, 1987.**

(8) "Integrated Work Setting" means job sites where most coworkers are not handicapped and individuals with handicaps are not part of a work group of other individuals with handicaps; or individuals with handicaps are part of a small work group of not more than eight individuals with handicaps; or individuals with handicaps have regular contact with non-handicapped individuals other than personnel providing support services in the immediate work setting.

(9) "Local Mental Health Authority" means an entity operating under an intergovernmental agreement or a direct contract with the Mental Health and Developmental Disability Services Division to

administer a community mental health program in a specific geographic area of the state.

(10) "Ongoing Support" means continuous or periodic job skill training or support services provided at least twice monthly at, or away from the work site, throughout the term of employment to enable the individual to perform the work.

(11) "Supported Employment" means paid employment averaging at least 20 hours per week accompanied by ongoing support which occurs individually, or in groups of no more than eight workers with disabilities, in a variety of integrated work settings.

(12) "Transitional Employment" means competitive work in an integrated work setting for individuals with chronic mental illness who may need support services but not necessarily job skills training services to perform the work. Such services may be provided either at the work site or away from the work site. The job placement may not necessarily be a permanent employment outcome for the individual.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

309-032-0230
Client Eligibility

Supported Employment Services shall enroll and serve only persons who:

(1) Are chronically mentally ill;

(2) Are enrolled in and actively served by a Community Support Unit;

(3) Have completed Vocational Rehabilitation Division evaluation or training;

(4) Require ongoing support by the program due to one or more of the following problems:

(a) Repeated failure to maintain employment;

(b) Poor ability to generalize skills from pre-employment training;

(c) Difficulty developing skills or production rates;

(d) Poor communication skills;

(e) Difficulty getting along with co-workers or supervisors;

(f) Inability to organize one's self to get to work regularly and on time; or

(g) Inability to deal with job stress.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

309-032-0235
Services to be Provided

Supported Employment Services shall provide either Supported Employment or Transitional Employment services to each client. Formal counseling services shall be provided through the Community Support Unit. The following employment related services shall be provided:

(1) Assessment of the supportive services needed by the client to succeed in a work environment.

(2) Ongoing support services which shall:

(a) Be individualized and based on the assessment of client need;

(b) Be described in the rehabilitation plan; and

(c) Include the following as needed by the client:

(A) Supervision and job training of client;

(B) On the job visits to provide support;

(C) Consultation with employer;

(D) Job coaching with the client, at and away from site;

(E) Emotional support;

(F) Coordination with professionals and family;

(G) Transportation;

(H) Individual social support activities; and

(I) Group social support activities.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

309-032-0240
Staff Qualifications

Supported Employment Services shall maintain position descriptions for all supported employment positions. The position descriptions shall require staff to be experienced in one or more of the following areas at the time of hire with the goal being for staff to acquire proficiency in all areas:

(1) Vocational training;

(2) Job coaching;

(3) Job Development of Placement; or

(4) Working with persons with chronic mental illness.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

309-032-0245
Case Record

Supported Employment Services shall maintain an individual case record for each client receiving services. The Supported Employment Services record may be a part of the Community Support Services record. The record shall:

(1) Contain an Intake Form prescribed by the Division;

(2) Contain a functional assessment of the client's strengths and deficits related to the client's ability to work;

(3) Contain relevant information from the client's participation in Community Support services;

(4) Contain an individual rehabilitation plan which outlines the ongoing support services to be provided;

(5) Contain progress notes documenting the client's movement toward specified rehabilitation goals. Progress notes shall be recorded when significant events occur and at least every other week;

(6) Contain monthly client progress summary forms prescribed by the Division;

(7) Contain periodic reviews of the rehabilitation plan identifying any changes in the services needed to allow the client to succeed in the work environment. Reviews of the rehabilitation plan shall be conducted every 90 days or more frequently if required by the client's condition;

(8) Be kept confidential in accordance with ORS 179.505, **45 CFR 204.50**, **42 CFR Part 2** and current edition of the Division's **Handbook in Confidentiality**;

(9) Be stored securely and retained in accordance with applicable Oregon Revised Statutes, Oregon Administrative Rules and Division policies;

(10) Contain a copy of a CPMS enrollment form completed and submitted a the time Vocational Rehabilitation Division training ends and the client enters Supported Employment services; and

(11) Contain a CPMS termination form and discharge summary within 30 days of the client's termination from Supported Employment Services.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

309-032-0250
Variances

A variance from these rules may be granted to an agency in the following manner:

(1) An agency requesting a variance shall submit, in writing, through the community mental health program to the appropriate program or administrative office:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the local mental health authority indicating its position on the proposed variance.

(2) The assistant administrator of the program or administrative office shall approve or deny the request for variance.

(3) The program or administrative office shall notify the community mental health program of the decision. The community mental health program will forward the decision and reasons therefore to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the program or administrative office with a copy to other relevant sections of the Division.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division, whose decision shall be final.

(5) A variance granted by the Division shall be attached to, and become part of, the contract for that year.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 7-1988, f. & cert. ef. 6-28-88

Standards for Community Treatment and Supervision of Persons Under the Jurisdiction of the Psychiatric Security Review Board (PSRB)

309-032-0455
Definitions

As used in these rules:

(1) "Case Number" means the unique identification number assigned to each client by the provider. No more than one such number shall be assigned to the client, and that number shall be identical for both the client's treatment record and CPMS enrollment. Once assigned, the case number must be retained for all subsequent admissions or periods of service for the client.

(2) "Client" means a person who is under the jurisdiction of the PSRB and receiving services under these rules.

(3) "Client Identifying Information" means specific personal, biographical, and demographic information about the client.

(4) "Community Mental Health Program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Division.

(5) "Conditional Release" means placement by a court or the PSRB, of a person who has been found eligible under ORS 161.327(b) or 161.336, for supervision and treatment in a community setting.

(6) "CPMS" or "Client Process Monitoring System", means an automated client data system maintained by the Division. "CPMS" shall also mean any subsequent modification or change to this system.

(7) "Data Base" means that collection of client information obtained through the mental health assessment process. It includes, but is not limited to: Identifying information, behavioral description, presenting problem(s), psychosocial and medical histories, developmental history, mental status, and current health information.

(8) "Diagnosis" means a DSM diagnosis determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment.

(9) "DSM" means the current edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.

(10) "Division" means the Addictions and Mental Health Division of the Department of Human Services.

(11) "Goal" means the broad aspirations or more final objectives toward which the client is striving, and toward which all services are intended to assist the client.

(12) "Health History" means a review of the client's current and past state of health as reported by the client, including:

(a) History of any significant illnesses, injuries, allergies, or drug sensitivities; and

(b) History of any significant medical treatments, including hospitalizations and major medical procedures.

(13) "Informed Consent" means the client or guardian understands a specific diagnosis and consents to service procedures and is informed of the risks or benefits, alternative services and procedures and the consequences of not receiving a specific service or procedure.

(14) "Licensed Medical Professional" means a medically trained person who is licensed to practice in the State of Oregon and has one of the following degrees: MD (Medical Doctor); DO (Doctor of Osteopathy); NP (Nurse Practitioner); PA (Physician's Assistant); or RN (Registered Nurse).

(15) "Local Mental Health Authority", as described in ORS 430.620, means the county court or board of county commissioners or one or more counties who choose to operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation.

(16) "Medication Use Record" means information kept in the client's treatment record which documents medications and/or agents prescribed or recommended by the provider's employed or contracted licensed medical professional who has prescriptive privileges, and includes medication progress notes as applicable.

(17) "Mental Health Assessment" means a process in which the client's need for mental health services is determined through evaluation of the client's strengths, goals, needs, and current level of functioning.

(18) "Mental Status Examination" means an overall assessment of a person's mental functioning that includes descriptions of appearance, behavior, speech, mood and affect, suicidal/homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, concentration, general knowledge, abstraction abilities, judgment, and insight.

(19) "Objective" means an interim level of progress or a component step that is necessary or helpful in moving toward a goal.

(20) "Progress Note" means a written summary of how the client is progressing with respect to the client's treatment plan.

(21) "Provider" means:

(a) An organizational entity which is operated by, or contractually affiliated with, a community mental health program, and is responsible for the direct delivery of mental health services to clients; or

(b) A public agency or private corporation or an individual, as provided for in ORS 161.390.

Notwithstanding the conditions of certification in OAR Chapter 309, the Division may contract directly with a community mental health and developmental disabilities program, other public agency or private corporation or an individual to provide supervision and treatment for a conditionally released person.

(22) "Psychiatric Evaluation" means an assessment performed by a licensed medical professional with prescriptive privileges who is a qualified mental health professional.

(23) "Qualified Mental Health Associate" (QMHA) means a person who delivers services under the direct supervision of a qualified mental health professional, and who meets the following minimum qualifications:

(a) Has a bachelor's degree in a mental health related field; or

(b) Has a combination of at least one year's work experience and two years education, training or work experience in mental health.

(24) "Qualified Mental Health Professional" (QMHP) means a person who meets all of the following minimum qualifications:

(a) Fits one of these categories:

(A) Psychiatrist or physician, licensed to practice in the State of Oregon; graduate degree in psychology, social work, or other mental health related field; graduate degree in psychiatric nursing, licensed in the State of Oregon; registration as an occupational therapist; graduate degree in recreational therapy; or

(B) Any other person whose education and experience meet, in a determination process approved by the Division, a level of competence consistent with the standards established for qualified mental health professionals.

(b) Has demonstrated competence to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships; conduct a mental status assessment; document a DSM diagnosis; write and supervise a treatment plan; and provide individual, family, and/or group therapy.

(25) "Qualified Person" means a person who is a qualified mental health professional, or a qualified mental health associate, is identified by the PSRB in the Conditional Release Order and who is designated by the provider to deliver and/or arrange and monitor the provision of required reports and services in this rule.

(26) "Treatment plan" means an individualized, written plan defining specific treatment objectives and proposed service interventions derived from the client's mental health assessment, and the Conditional Release Order.

(27) "Treatment Record" means a separate file established and maintained under these rules for each client.

(28) "Service Supervisor" means a person who has two years of experience as a qualified mental health professional and who, in accordance with OAR 309-032-0505, reviews the services provided to clients by qualified persons.

(29) "Setting" means the location at which a service is provided, and includes, but is not limited to: CMHP office, client's residence, or other identified location.

(30) "Significant Procedure" means a diagnostic or service modality which may have a substantial adverse effect on the client's psychological or physical health, such as administration of medications which have serious side effects.

(31) "Supervision" means monitoring of client's compliance with Conditional Release Orders, Agreement to Conditional Release, the treatment plan requirements, and any additional monitoring and reporting requirements stipulated by the PSRB, the courts, or the Division, not otherwise specified in these rules.

(32) "Termination Summary" means a summary of client progress toward treatment objectives from the time of admission to the termination of services.

(33) "Utilization Review" means a process in which client treatment records are examined by a review committee to evaluate the need for, and appropriateness of services, as well as completeness of the record.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07; MHS 11-2007(Temp), f. & cert. ef. 8-31-07 thru 2-27-08

309-032-0460
General Standards

Providers of mental health evaluations and services under Orders for Evaluation and/or Orders of Conditional Release shall provide all reports and notifications ordered by the PSRB, under ORS 161.295 through 161.430, or otherwise required in this rule and other law. These responsibilities do not conflict with adherence to client rights under this rule and other Oregon statutes.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0465
Order for Evaluation

Following the receipt of an Order for Evaluation from the PSRB, the provider will:

(1) Within 15 days of receipt of the Order, schedule an interview with the client for the purpose of initiating or conducting the evaluation;

(2) Appoint a qualified mental health professional to conduct the evaluation and to provide an evaluation report to the PSRB;

(3) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB responding to the questions asked in the Order for Evaluation; and

(4) If supervision by the provider is recommended, notify the PSRB of the name of the person designated to serve as the client's Qualified Person, who will be primarily responsible for delivering or arranging for the delivery of services and the submission of reports under these rules.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0470
Periodic and Special Circumstance Reports to the PSRB

The service provider, acting through the designated Qualified Person, shall submit reports to the PSRB as follows:

(1) Monthly reports. Monthly reports consistent with PSRB reporting requirements as specified in the Conditional Release Order that summarize the client's adherence to Conditional Release requirements and general progress in treatment. Reports are to be received by the PSRB by the tenth day of the month following the reporting period;

(2) Interim reports. Prompt interim reports, including immediate reports by phone, if necessary, to ensure the public's or client's safety including:

(a) At the time of any significant change in the client's clinical, legal, employment or other status which may affect compliance with Conditional Release orders;

(b) Upon noting major symptoms of a psychiatric decompensation requiring psychiatric stabilization or hospitalization or any other major change in the client's treatment plan;

(c) Upon learning of any violations of the Conditional Release Order;

(d) At any other time when, in the opinion of the Qualified Person, such an interim report is needed to assist or protect the client or to protect public safety.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0475
Minimum Treatment Services

Treatment services shall include all appropriate services determined necessary by the Community Mental Health Program or the Provider to assist the client in maintaining community placement and which are consistent with Conditional Release Orders and the Agreement to Conditional Release. Treatment shall include:

(1) Medication management and monitoring;

(2) Substance abuse treatment or referral;

(3) Group, family, and individual counseling services;

(4) Health care services. The providers shall directly provide, or refer for, available health care services to the extent they are necessary for continuation of conditional release;

(5) Life skills training; and

(6) Hospital services. The provider shall directly provide or arrange for psychiatric hospital services, if needed as follows:

(a) Voluntary psychiatric hospitalization. At the discretion of the Qualified Person, and in consultation with the PSRB Executive Office, clients may be returned to psychiatric hospitalization on a voluntary basis. These returns may be prompted by a deterioration in mental status, violations of Conditional Release Orders, or at the request of the Qualified Person or the client;

(b) Conditional release revocation. If a client requires involuntary return to a State Psychiatric Hospital or center, revocation procedures shall be initiated through the PSRB. If the CMHP or the provider is unable to consult immediately with the PSRB when it is necessary to hospitalize a client involuntarily, the PSRB Executive Office shall be notified of actions taken by the next working day.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0480
Policies and Procedures

Each provider shall have written policies and procedures governing the following:

(1) Establishment, maintenance, and contents of treatment records;

(2) Confidentiality of treatment records;

(3) Safety, storage, and retention of treatment records;

(4) Client rights specific to services received, and client appeal process and grievance procedures;

(5) Client participation in treatment and termination planning;

(6) Assessment, evaluation, and planning for client treatment needs;

(7) Performance and documentation of medical services;

(8) Establishment and maintenance of medication use record;

(9) Performance and documentation of staff supervision;

(10) Performance and documentation of utilization review; and

(11) Client Revocation of the client's community placement when the client requires involuntary hospitalization and/or fails to comply with Conditional Release Orders.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0485
Consumer Rights Specific to Services Received

In addition to client rights delineated in applicable Oregon Revised Statutes, Oregon Administrative Rules, and elsewhere in these rules, the following shall be required specific to services received:

(1) Notification of rights. At the time of enrollment, the provider shall make available to the client or guardian a document that describes the client's rights and responsibilities.

(2) Services refusal. The client shall have the right to refuse service, including any specific procedure, unless ordered by a court or the PSRB.

(3) Grievances. The client shall have the right to lodge a grievance.

(4) Access to records. The client shall have the right to access the client's own treatment records in accordance with state and federal law, including ORS 179.505, 192.505, 45 CFR 205.50, 42 CFR Part 2.

(5) Informed participation in treatment planning. The client shall be afforded the opportunity participate in an informed way in planning his or her treatment unless this participation would jeopardize the client's treatment.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0490
Establishment and Maintenance of Treatment Record

(1) Individuality of records and maintenance. A separate, individual treatment record shall be opened and maintained for each eligible and enrolled PSRB client receiving services from the provider, including the instance in which more than one eligible and enrolled member of a family receives services from the same provider.

(2) Organization of records. Each treatment record shall be maintained to assure accessibility, uniform organization, and completeness of all components required by these rules.

(3) Signature of authors. All documentation required in this rule must be signed by the staff providing the service and making the entry. Where required, the entry must be signed by the supervisor signifying approval of the material. Each staff and supervisor signature must include the person's academic degree or professional status and the date signed.

(4) Documentation of client consent. All procedures in these rules requiring client consent shall be documented in the record on forms describing what the client has been asked to consent to, and signed and dated by the client or client representative.

(5) Error corrections. Errors in the record shall be corrected by lining out the incorrect data with a single line in ink, and then adding the correct information, the date corrected, and the initials of the person making the correction.

(6) Confidentiality of other clients. References to other clients, when included in the individual client's record, shall preserve the confidentiality of the other clients.

(7) Security. Treatment records shall be secured, safeguarded, stored, and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules. The PSRB shall provide copies of all reports to the client and to the client's counsel as required by ORS 161.336(4)(d).

(8) Confidentiality of treatment records. All individuals' records are confidential except as otherwise indicated by applicable rule or laws:

(a) For the purpose of disclosure from individual medical records under these rules, service providers under these rules shall be considered "providers" as defined in ORS 179.505 and 179.506(1) shall be applicable;

(b) For the purposes of disclosure from non-medical individual records, both the general prohibition against disclosure of "information of a personal nature" and limitations to the prohibition in ORS 192.502(2) shall be applicable;

(c) This does not restrict the provider from submitting reports required in this rule to the court or the PSRB without a client's signed release of information.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0495
Documentation of Protection of Client Rights

Treatment records shall document adherence to the client's rights:

(1) Client consent to enrollment in treatment services. At the time of enrollment, the client or guardian shall sign a document or documents which verifies the client has been informed of all client rights referred to in OAR 309-032-0485 Client; and that the client consents to evaluation and services prior to development of the treatment plan.

(2) Consent to specific treatment services. At the time of treatment plan development the qualified mental health professional responsible for development of the treatment plan shall obtain client or guardian signed consent to the treatment approaches recommended, and include this documentation in the service record.

(3) Consent to significant procedures. Whenever a significant procedure is proposed, the client's or guardian's signature verifying informed consent to the procedure shall be obtained and included in the treatment record.

(4) Refusal to consent. If the client refuses recommended treatment services, or refuses to consent to a procedure as required in these rules, the client's refusal shall be documented in the service record and the PSRB notified. The reasons for refusal and efforts to obtain the client's signature shall be documented in the client's treatment record.

(5) Documentation of disclosure of fee policy. The service record shall include documentation signed by the client verifying that fees the client will be asked to pay have been described.

(6) Authorization to release information. The service record must include documentation signed by the client authorizing any release of information by the type of information and the recipient of information.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0500
Client Identification and Documentation of Service Needs and Delivery

Treatment records shall document the gathering of information, conduct of assessments, planning, reviews, and the provision of services as follows:

(1) Client identifying information. Client identifying information must be obtained by a QMHA OR QMHP. The information must be readily identifiable and accessible in the client's record, and include the following:

(a) The unique case number assigned to the client;

(b) The client's name;

(c) The client's gender, age, and marital status;

(d) The client's phone number and address;

(e) Who to contact in case of an emergency and the phone or address at which contact may be made;

(f) A copy of the CPMS enrollment form(s).

(2) Conditional release orders. A copy of the Order of Conditional Release and the Agreement to Conditional Release shall be included in the client's record.

(3) Mental health assessment. A mental health assessment shall be completed for each client within 60 days of enrollment and prior to the initial review of the treatment plan. The assessment must be completed by a QMHP who shall sign and date the final page of the assessment. The service supervisor, a psychiatrist, or a physician who is a QMHP shall review, sign and date the assessment within 60 days of the client's enrollment. The assessment must include the following elements that must be readily accessible and identifiable in the record:

(a) A statement of the client's initial goal(s) in seeking or entering treatment services and a description of events precipitating enrollment, and their related history;

(b) Historical information shall be obtained from the client, or other sources when appropriate, including but not necessarily limited to:

(A) Mental health history;

(B) Health history;

(C) Substance use and abuse history;

(D) Developmental history;

(E) Social history, including family and interpersonal history;

(F) Educational, vocational, and employment history; and

(G) Legal history.

(c) A determination of the client's functional strengths and deficits including, but not necessarily limited to daily living, social and vocational skills, and current support system;

(d) A mental status examination;

(e) A summary of significant and pertinent data from the mental health assessment including client strengths and deficits;

(f) A DSM diagnosis, supported by data obtained in the assessment;

(g) Preliminary recommendations for treatment services, including psychosocial and medical interventions, additional examinations, tests, and evaluations that are needed; and

(h) A disposition statement about how the client will be served by the provider, and/or referred elsewhere, and if referred, the reasons for referral.

(4) Treatment goal identification. The treatment goals including those articulated by the client shall be recorded in the treatment record so as to be readily identifiable and accessible. Each goal must derive from the mental health assessment, and be updated as follows:

(a) To reflect significant changes in the client's status which may affect goal pursuit; and

(b) When significant new goals are identified.

(5) Treatment plan and the PSRB Order of Release. An individualized treatment plan, developed from the mental health assessment, and the client's goals so far as possible, must be completed, signed and dated by a QMHP within 60 days of the client's enrollment. The plan must be readily identifiable and accessible within the treatment record and be written at a level of specificity that will permit its subsequent implementation to be efficiently monitored and reviewed. The recorded plan shall contain the following minimum components:

(a) Specific objectives that clearly state in language understandable to the client, the component steps, or outcomes for each treatment goal, and the criteria for determining when each objective or outcome is attained;

(b) The specific services or interventions to be used to achieve each objective;

(c) The projected frequency and duration of services;

(d) Specific efforts to be undertaken by the clients both:

(A) As a participant in services being offered by the provider; and

(B) Those to be undertaken by the client personally in their daily or ongoing living activities.

(e) Identification of the qualified person assigned to the client who is responsible for coordinating services.

(6) Client participation in treatment planning. The QMHP responsible for providing services to the client must document in the client's treatment record that:

(a) The treatment goals including the client's goals for seeking services, as noted in the assessment, have been discussed with the client and consented to;

(b) The proposed treatment activities and service approaches have been discussed with the client and consented to;

(c) The provider is exempt from complying with subsection (a) or (b) of this section if the QMHP documents in the treatment record that the client is unable to participate as required in subsection (a) or (b) of this section; or, that such participation would jeopardize the client's treatment;

(d) When and if the circumstances which prevented the completion of one or more actions required by subsection (a) or (b) of this section change, such that client participation and consent can occur, the client must be afforded the opportunity to participate in the activities, and that participation must be documented in the treatment record.

(7) Medical services. Psychiatric evaluation services, and within resources specifically allocated for the purpose, other medical screening services, shall be provided. Delivery of any such services must be documented so as to be readily accessible and identifiable in the client's record, and must meet the following standards:

(a) Psychiatric evaluations shall be performed by a medical professional who is a psychiatrist, other physician, or licensed medical professional with prescriptive privileges, any of whom must be a QMHP:

(A) If the evaluation is performed by the provider's employed or contracted medical professional, it must be completed within 60 days of the client's enrollment, unless a similar evaluation was performed within 180 days prior to the enrollment. A psychiatric evaluation must be performed at least once annually. The evaluation must contain pertinent psychiatric history and information, a psychiatric diagnostic statement, and identification of medications recommended for the client's psychiatric condition;

(B) If the evaluation is performed by a medical professional not employed by, or under contract to, the provider, a summary of the evaluation must be obtained in a timely manner and include a diagnostic statement and medications recommended.

(b) If resources have been allocated for the purpose, medical screenings as follows will be provided to determine whether the client has organic diseases or conditions that cause or exacerbate the client's mental or emotional disturbance:

(A) A comprehensive health history;

(B) A physical examination;

(C) A blood chemistry screening; and

(D) Other laboratory, radiological, or diagnostic tests that may be indicated by history and physical examination.

(c) Medical screening shall be ordered within 60 days after enrollment of the client, unless a screening was performed within 180 days prior to enrollment. The data collected from the medical screening must be reviewed by a licensed medical professional, and the findings and interpretation(s), along with the licensed medical professional's recommendations for further medical tests, evaluations and treatment, filed in the treatment record;

(d) All orders for medication, laboratory and other medical procedures issued by medical staff of the provider shall be recorded in the treatment record in conformance with standard medical practice. Such orders, whether written or verbal, shall be initiated and authenticated by a licensed medical professional with prescriptive privileges. Relevant medical orders issued by medical personnel not employed by, or under contract to, the provider shall be documented through periodic consultation or exchange of information;

(e) A medication use record documenting all medications or agents prescribed or recommended for the client shall be signed by the provider's licensed medical professional having prescriptive privileges and shall be maintained so as to be readily identifiable and accessible in the treatment record. Documentation for each medication or agent prescribed or recommended shall include the following:

(A) Name of medication or agent;

(B) Dosage and method of administration;

(C) Dates prescribed, reviewed, or renewed;

(D) If administered by provider staff, the dates administered, and the signature and identification of the staff person(s) administering the medication; and

(E) Observed affects and side effects, including laboratory findings and corrective actions taken for side effects.

(8) Progress notes. Progress notes, documenting client progress toward meeting treatment plan objectives, must be recorded so as to be readily identifiable and accessible within the client's treatment record, and must meet the following requirements:

(a) A progress note shall be recorded and signed by the qualified person providing the service each time a service is provided; or at any time a significant change occurs in the client's condition;

(b) Each progress note shall specify the service(s) provided, the date provided, and the amount of time it took to delivery each service. As appropriate, progress notes shall document:

(A) Periodic discussions with the client concerning progress or difficulty in meeting objectives identified in the treatment plan;

(B) Significant changes in the client's condition including, at a minimum, documentation of changes in the client's mental status;

(C) Description of situational problems arising and their effect on the client;

(D) Description of modifications to the treatment plan that are necessary due to paragraphs (A), (B), and (C) of this subsection; and

(E) Description of services provided that depart from the treatment plan.

(9) Periodic review of assessment and plan. A review and update of each client's mental health assessment and treatment plan shall occur at least annually, unless greater frequency is required by client needs, OAR 309-0160080, or the PSRB. A copy of the review and update shall be submitted to the PSRB. Reviews and updates must be recorded so as to be readily identifiable and accessible within the treatment record and must be signed by the QMHP providing services and by supervisory personnel:

(a) The Mental Health Assessment review and update must include:

(A) An interim history, including significant changes in the client's environment, functioning, and mental status;

(B) A summary of treatment interventions used and client response; and

(C) Any change in diagnosis.

(b) The Treatment Plan review shall summarize client's progress toward meeting treatment objectives and shall include updates of, or modifications to, the treatment plan objectives.

(10) Services termination summary. A services termination summary shall be completed for each client for whom the provider no longer assumes treatment responsibility. The summary must be prepared and signed by the QMHP responsible for the provision of services to the client, and be readily identifiable and accessible within the client's treatment record. The summary must be formulated and written and the client's record closed no later than 90 days after the last treatment service contact with the client, unless otherwise specified in the treatment plan. This requirement for closure of the client's treatment record is independent of, and unrelated to, requirements for CPMS termination:

(a) The services termination summary shall include the following minimum information:

(A) The date of termination, including the date of last contact with the client;

(B) Reasons for termination;

(C) Summary of client progress for each treatment goal identified;

(D) Summary of client's status and level of functioning, including goals not accomplished; and

(E) Prognosis and recommendations for further services.

(b) In the case of a client's discharge from PSRB jurisdiction, the client, to the extent able, and family members or significant others, to the extent appropriate, shall participate in services termination planning. Such participation shall be documented;

(c) Client non-appearance. When treatment responsibility is terminated for a client who no longer appears for services, the provider must document efforts made to locate or contact the client, and, for any client remaining under PSRB jurisdiction, immediately notify the PSRB.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0505
Service Supervision

Except as provided for by section (2) of this rule, any staff providing services to a client shall be supervised:

(1) Approval of treatment plan. The service supervisor, or a psychiatrist, or a physician who is a QMHP shall review and approve by signature, the treatment plan and each periodic plan update for each client. The review(s) shall determine the appropriateness of the relationship between client needs, proposed services, services provided, and intended results. Reviews shall, at minimum, include reviewing the client's case with the qualified person(s) providing services to the client or by examining the client's treatment record.

(2) Service supervision exceptions. Notwithstanding the supervision requirements above, the provider may modify the requirements specified in these rules for supervision of staff:

(a) Who are licensed under Oregon Revised Statutes to conduct private practice without supervision (such as a physician, psychologist, or social worker); and

(b) Who are qualified mental health professionals; and

(c) Whose activities are not required to be supervised by OAR 309-016-0075 and 309-016-0080; or

(d) Who are supervisors not under supervision of another supervisor, and whose activities are not required to be supervised by OAR 309-016-0075, and 309-016-0080.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0510
Utilization Review

Utilization reviews shall be conducted quarterly in accordance with applicable administrative rules and must include at least the following components:

(1) Completeness review. Client records shall undergo a completeness review to determine that all entries necessary to document services are present, that the records are accurate, and that the records contain all information, forms, and signatures required by these rules. The completeness review shall be conducted every quarter on a random sample of at least three percent of all active PSRB cases with no fewer than three of those cases not subject to reviews required by OAR 309-016-0090. If fewer than three PSRB service clients are enrolled, the completeness review must include each client's record.

(2) Content review. The content of client records shall be examined by a committee consisting of at least the following members:

(a) A QMHP on the staff of the provider;

(b) A QMHP not on the staff of the provider; and

(c) A licensed medical professional who is a QMHP and, when necessary, meets additional requirements set by OAR 309-016-0090 concerning Utilization Review Requirements;

(d) The content review shall be conducted on a random sample of at least three percent of all active cases, with no fewer than three cases selected for the sample, or all PSRB service clients if fewer than three persons are enrolled. The review shall meet any additional sampling requirements set by OAR 309-016-0090.

(3) Utilization review summary. Upon completion of each quarterly utilization review a summary shall be written of both the content review and the completeness review findings, presented to the provider director or designee, and retained in the provider's files. The summary shall include recommended corrective action(s), if any. Corrective actions taken shall be documented in the appropriate file.

(4) Utilization review records access. Utilization reviews of client records shall be available for examination by appropriate local, state, and federal agency representatives.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

309-032-0515
Variances

(1) Criteria for a variance. Variances may be granted to a CMHP or a provider if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The CMHP or provider requesting a variance shall submit, in writing, an application to the Division that contains the following:

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

(b) The reason for the proposed variance;

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

(d) A description of the individual's opinion and participation in requesting the variance;

(e) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(f) Signed documentation from the CMHP or the provider indicating its position on the proposed variance.

(3) Division review. The Assistant Director or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the CMHP or the provider of the decision. This notice shall be given to the CMHP or the provider within 30 days of the receipt of the request by the Division with a copy to other relevant sections of the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Assistant Director of the Division, whose decision shall be final.

(6) Written approval. The CMHP or the provider may implement a variance only after written approval from the Division. The intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every two years.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 161.295 - 161.430, 428.205 - 428.270
Hist.: MHD 2-1991, f. 1-30-91, cert. ef. 2-1-91; MHD 3-2006(Temp), f. & cert. ef. 11-1-06 thru 4-25-07; MHS 1-2007, f. & cert. ef. 4-24-07

Standards for Adult Mental Health Services

309-032-0525
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for community mental health rehabilitation services for adults. All adult mental health services provided under this rule will endeavor to promote recovery, independence and successful community living, by or through:

(a) Communication of hope, and promotion of emotional, behavioral and psychological growth through persistent efforts to attain individual goals;

(b) The promotion of skills and knowledge to help individuals effectively manage their mental health concerns and develop a sense of hope and sense of self that is not illness dominated; and

(c) Providing a humane service environment that affords reasonable protection from harm including retraumatization.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 430.640(1)(h) to carry out the provisions of ORS 426.490 through 426.500 and 430.630.

Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0535
Definitions

As used in these rules:

(1) "Abuse" means one or more of the following:

(a) Any death caused by other than accidental or natural means.

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury.

(c) Willful infliction of physical pain or injury.

(d) Sexual harassment or exploitation, including but nor limited to any sexual contact between and employee of a facility or community program and an adult.

(2) "Adult" means and individual 18 years of age or older.

(3) "Case Management" means services provided by a QMHP or QMHA to a consumer who requires access to benefits and services from local, regional or state allied agencies or other service providers. Case management includes advocating for the consumer's treatment needs, providing assistance in obtaining entitlements based on mental or emotional disability, accessing housing or residential programs, coordinating services including mental health treatment, educational or vocational activities, and arranging alternatives to inpatient hospital services.

(4) "Client Process Monitoring System" or "CPMS," means the automated consumer data system maintained by the Division.

(5) "Clinical Formulation" means the documentation of the clinical judgments which lead to decisions in regard to diagnosis, prognosis, the priority and sequences of treatment goals and to the type and intensity of clinical interventions described in the treatment plan.

(6) "Clinical Record" means a collection of all documentation regarding a consumer's mental health treatment and related services. It is a document and provides the basis by which the provider manages service delivery and quality management. For the purpose of confidentiality, it is considered a medical record as defined in ORS Chapter 179.

(7) "Community Mental Health Program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Division.

(8) "Consumer" means an adult who receives or is eligible to receive mental health services from a provider funded and authorized through the Division.

(9) "Declaration for Mental Health Treatment" means a document that states the consumer's preferences or instructions regarding mental health treatment as defined by ORS 127.000 through 127.737.

(10) "Diagnosis" means the principal mental disorder(s) identified in a five axis diagnosis listed in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, that constitutes the medically appropriate reason for clinical care and the main focus of treatment for a consumer. The diagnosis is determined through the mental health assessment and any examinations, tests, procedures, or consultation suggested by the assessment.

(11) "Discharge" means the conclusion of the planned course of services described in the individualized treatment plan, regardless of outcome or attainment of goals described in the individualized treatment plan.

(12) "Discharge Summary" means a written description of consumer status and progress related to goals and objectives listed in the treatment plan form the time of admission to the termination of services.

(13) "Division" means the Mental Health and Developmental Disability Services Division of the Oregon Department of Human Services.

(14) "Goal" means an expected result or condition to be achieved that provides a guideline for the direction of care, is reasonable and realistic, and is related to an identified need or problem in the treatment plan. It also identifies what the consumer wishes to achieve.

(15) "Informed Consent" means the consumer and, if appropriate, guardian, after being provided with a description of the proposed services and information concerning potential risks and benefits of service procedures, has voluntarily agreed to participate in the services. This includes his/her right to participate in the development and periodic review of an individualized treatment plan, to be informed of his/her diagnosis (after the mental health assessment has been conducted), and an explanation of the purpose of any prescribed medication and potential side effects. The consumer is also informed of his/her right to withdraw consent and file a grievance at any time.

(16) "Licensed Medical Practitioner" or "LMP" means a person who meets the following minimum qualifications as documented by the LMHA or designee:

(a) Holds at least one of the following educational degrees and a valid license:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse practitioner licensed to practice in the State of Oregon; or

(C) Physician's assistant licensed to practice in the State of Oregon;

(b) Whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management; and

(c) When the LMP is not a psychiatrist, the LMP is required to have access to consultation services provided by a psychiatrist, either through directs employment by the provider or through written contract between the LMP and the consulting psychiatrist.

(17) "Local Mental Health Authority" (LMHA) means the county court or board of county commissioners of one or more counties who choose to operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation which contracts with the Division to operate a CMHP for that county.

(18) "Medication use record" means information kept in the consumer's clinical record which documents medications and/or agents prescribed or recommended by, a LMP and includes medication progress notes as applicable.

(19) "Mental Health Assessment" means a process in which the consumer's need for mental health services is determined through evaluation of the consumer's strengths, goals, needs, and current level of functioning.

(20) "Objective" means the written statement of an expected result or condition that is related to the attainment of a stated or specified goal. The objective is stated in measurable terms and has a specified time for accomplishment. This also means a step identified in order for a consumer to attain his/her individual goal.

(21) "Outreach" means the delivery of mental health services, referral services and case management services in non-traditional settings, such as, but not limited to, the consumer's residence, shelters, streets, jails, transitional housing sites, drop-in centers or single room occupancy hotels.

(22) "Personal Care Plan" means a written plan which a case manager or other designated person develops for persons with mental

illness after assessing an individual and considering the individual's physician orders if any. The plan is developed jointly among the consumer, case manager, and residential caregiver, and identifies the care and services to be provided by the caregiver.

(23) "Persons Diagnosed with Serious Mental Illness" means an individual who is:

(a) Diagnosed by a QMHP as suffering from a chronic mental disorder as defined by ORS 426.495(2)(b) which includes, but is not limited to, conditions such as schizophrenia, serious affective and paranoid disorders, and other disorders which manifest symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism; which continue for more than one year, or on the basis of a specific diagnosis, are likely to continue for more than one year; and

(b) Is impaired to an extent which substantially limits the person's consistent functioning in one or more of the following areas:

(A) Home environment: independently attending to shelter needs, personal hygiene, nutritional needs and home maintenance;

(B) Community negotiation: independently and appropriately utilizing community resources for shopping, recreation and other needs;

(C) Social relations: establishing and maintaining supportive relationships;

(D) Vocational: maintaining employment sufficient to meet personal living expenses or engaging in other age appropriate activities.

(24) "Program" means an organization or other entity certified in accordance with this rule to provide community mental health services to adults.

(25) "Progress Note" means a written summary of how treatment modalities are implemented as described in the consumer's treatment plan.

(26) "Provider" means an organizational entity, agency or individual certified and/or authorized by the Division or its contractors to deliver mental health services to consumers.

(27) "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the supervision of a QMHP, and who meets the following minimum qualifications as documented by the LMHA or designee:

(a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three year's work, education, training or experience; and

(b) Has the competencies necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts;

(C) Provide psychosocial skills development; and

(D) Implement interventions prescribed on a treatment plan.

(28) "Qualified Mental Health Professional" or "QMHP" means any person designated by the LMHA as a QMHP prior to the adoption of this rule, a LMP, or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

(a) Possess one of the following education degrees:

(A) Graduate degree in psychology;

(B) Bachelor's degree in nursing and licensed by the State of Oregon;

(C) Graduate degree in social work;

(D) Graduate degree in a behavioral science(s) field;

(E) Graduate degree in recreational art, or music therapy; or

(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(b) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental, emotional and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships; conduct a mental status assessment; document a multiaxial DSM diagnosis; write and implement or supervise implementation of a treatment plan; conduct and document a mental health assessment; and provide mental health treatment and rehabilitative services within the scope of his or her practice.

(29) "Recovery" means the process of a person regaining his/her health, safety, and independence following a diagnosis of a psychiatric disorder.

(30) "Supervisor" means a QMHP who has two years of post-graduate experience providing mental health services to adults and who, in accordance with this rule, reviews and oversees the services provided to consumers.

(31) "Treatment plan" means an individualized, written plan developed by a QMHP with consumer involvement which is based on the consumer's mental health assessment and defines specific service and treatment goals and objectives and the proposed interventions.

[Publication: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430.041 & 430.640

Stats. Implemented: ORS 426.490 - 426.500 & 430.630

Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0545

Adult Mental Health Services

(1) In accordance with ORS 426 and ORS 430 the following services shall be provided:

(a) Crisis services shall be readily available and include the following:

(A) 24 hours, seven days per week telephone or face-to-face screening to determine a person's need for immediate community mental health services; and

(B) Development of a written initial crisis plan which includes a provisional diagnosis and a brief description of the services necessary to help the individual effectively manage his/her mental health crisis.

(b) Mental health assessment and treatment planning;

(c) Coordination of services including housing, employment, and case planning with other agencies and resources;

(d) Medication management as identified in the consumer's individualized treatment plan;

(e) Individual, family and group therapies and other community-based services identified in the consumer's individualized treatment plan.

(2) In addition to the services listed in OAR 309-032-0545(1) case management services shall be made available to persons diagnosed with serious mental illness in accordance with ORS 426.500(3) and include the following:

(a) Assistance in applying for benefits to which the consumer is entitled. Staff shall routinely help consumers secure resources such as Social Security benefits, General Assistance, food stamps, vocational rehabilitation, and housing assistance. When needed, staff shall accompany consumers to help them apply for benefits.

(b) Assistance in helping the consumer complete and update a personal crisis plan or a declaration for mental health treatment with the consumer's participation and informed consent.

(c) Outreach services to help consumers gain access to needed services;

(d) Symptom-management efforts directed to help each consumer identify the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen their effects;

(e) Promote linkages to work-related services that help the consumer find and maintain employment in community-based job sites;

(f) When a consumer resides in a Residential Treatment Home or Residential Treatment Facility, the case manager will collaborate with the facility to arrange the necessary treatment services and coordinate residential and nonresidential treatment;

(g) When a consumer is placed in an Adult Foster Home, the case manager will assist in development of the Personal Care Plan. Additionally, the case manager shall evaluate the appropriateness of services in relation to the consumers assessed need and review the Personal Care Plan every 180 days;

(h) When a consumer is admitted to a hospital or nonhospital facility for psychiatric reasons, the case manager shall make contact in person or by telephone with the consumer within one working day of admission. The consumer's case manager shall be actively involved with discharge planning from the hospital or nonhospital facility;

(i) If a consumer is hospitalized in a state psychiatric hospital, the case manager shall, from the point of admission, be actively involved with discharging the consumer from long term care; and

(j) Monitoring health and safety needs for consumers who reside in community settings including residential programs licensed by the Department of Human Services. Where significant health and safety concerns are identified, the case manager shall assure that necessary services or actions occur to address the identified health and safety needs for the consumer.

Stat. Auth.: ORS 430.041 & 430.640

Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0555
Consumer Rights

In addition to consumer rights in applicable Oregon Revised Statutes, Oregon Administrative Rules, and elsewhere in these rules, the following is required specific to services received:

(1) Notification of rights. The provider shall make available to the consumer and, if appropriate, guardian a document which describes the consumers' rights and responsibilities, including, at a minimum, freedom from abuse as defined in ORS 430.735 by an employee of the provider. Information and material shall be provided to the consumers in written form or in alternative format or language appropriate to the consumers' need, upon request. The rights, responsibilities, and how to exercise them, shall be explained to the consumer, and if appropriate, guardian at the beginning of each episode of treatment. The specification of rights and responsibilities shall also be posted visibly in an area frequented by consumers.

(2) The consumer shall have a humane service environment that affords reasonable protection from harm and affords reasonable privacy.

(3) The consumer shall be provided services in a setting under conditions that are least restrictive to the person's liberty, that are least intrusive to the person and that provide for the greatest degree of independence.

(4) The consumer shall receive no services without informed voluntary written consent except as permitted by law.

(5) The consumer and others of the consumer's choice shall be afforded the opportunity to participate in the planning and provision of services with the consumer's consent.

(6) The consumer shall have the right to refuse services, including any specific procedure without suffering punitive consequences. If adverse consequences are expected to result from such refusal, that fact must be explained verbally to the consumer and, if appropriate, guardian.

(7) The consumer shall not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure.

(8) The consumer shall have access to and communicate privately with any public or private rights protection program or rights advocate.

(9) Grievance policy: The consumer shall have the right to file a grievance or complaint, free from retaliation, and receive assistance when needed in submitting a grievance or complaint. The program shall develop, implement, and fully inform consumers of policies and procedures that provide for:

(a) Receipt of oral and written grievances from consumer and, if appropriate, guardian acting on his/her behalf;

(b) Investigation of the facts pertaining to the grievance;

(c) Initiating action on substantiated grievance within a timely manner; and

(d) Documentation in the consumer's record of the receipt, investigation, and action taken regarding the grievance.

(10) Declaration of mental health treatment. The consumers shall be informed of their right to execute a declaration of mental health treatment.

(11) Informed consent to fee-for-service. The amount and schedule of payment of any fees to be charged must be disclosed in writing and agreed to by the consumer and, if appropriate, guardian.

(12) Respect and dignity. A provider shall maintain written policies and procedures with regard to a consumer's rights. The policies and procedures shall assure that the consumer's right to be treated with respect and dignity is safeguarded.

(13) Alternative format. Information and materials shall be provided to the consumer in written form or in an alternative format or language appropriate to the consumer's needs.

(14) Cultural Competence. A provider shall ensure that the provision of care is culturally appropriate by demonstrating both awareness of and sensitivity to cultural differences.

(15) Gender Specific. A provider shall ensure that the provision of care is gender appropriate by demonstrating both awareness of and sensitivity to gender differences.

(16) Mandatory abuse reporting. All providers are required to report incidents of abuse when the provider comes in contact with and has reasonable cause to believe that a consumer has suffered abuse.

(17) Prohibition of discrimination. All providers shall make reasonable modifications in policies, practices, and procedures to avoid discrimination.

(18) American with Disabilities Act (ADA). Providers shall comply with the ADA.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0565
Clinical Record

(1) An individualized clinical record shall be maintained for each consumer that includes the following:

(a) Basic identifying information:

(A) CPMS enrollment data where required;

(B) Identifying data including the consumer's name, address, telephone number, date of birth, gender and marital status;

(C) Name, address, and telephone number of legal guardian and family members or other persons to contact in case of an emergency as authorized by the consumer; and

(D) Name, address and telephone number of the consumer's physician;

(b) Written documentation that the consumer and, if appropriate, guardian consents voluntarily to services after being provided with a description of the proposed services and information concerning potential risks and benefits of service procedures. This includes his/her right to participate in the development and periodic review of an individualized treatment plan, to be informed of his/her diagnosis (after the mental health assessment has been completed), and the purpose of any prescribed medication and potential side effects. The consumer is also informed of his/her right to withdraw consent and file a grievance or request a hearing at any time.

(c) If the consumer has a validly executed declaration for mental health treatment, a copy of the declaration for mental health treatment as set forth in ORS 127.736 shall be placed in the clinical record in accordance with ORS 127.703(1)(b).

(2) Each program shall:

(a) Maintain the consumer clinical record for a minimum of seven years after the consumer has been discharged form services.

(b) Permit inspection of consumer clinical records upon request by the Division to determine compliance with these rules.

(c) Not falsify, alter, or destroy any consumer information required by these rules to be maintained in the clinical record.

(d) Maintain each clinical record to assure permanency, timely completion of documentation, identification, accessibility, uniform organization, and completeness of all components required by these rules. Errors in the permanent clinical record shall be corrected by lining out the incorrect data with a single line in ink, adding the correct information, and dating and initialing the correction. Errors may not be corrected by removal or obliteration through the use of correction fluid or tape so they cannot be read.

(e) Comply with state and federal laws and pertaining to confidentiality of consumer records and shall have authentication protocols for electronic consumer records to ensure the safety and integrity of confidentiality.

Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0575
Documentation of Clinical Services

All providers shall develop and maintain an individual, legible, clinical record for each consumer served under these rules which is completed in a timely manner. Documentation of clinical services shall include the following:

(1) Mental health assessment. The mental health assessment shall be conducted by a QMHP for all consumers receiving community mental health services and include a determination of the consumer's mental status and other documentation to support the determination of a DSM 5-Axis diagnosis and a written clinical formulation. The clinical formulation shall provide a description of the following:

(a) Presenting problems and/or concerns;

(b) Important biological, cultural, psychological and social factors which are a priority for intervention;

(c) Clinical events and/or course of illness including onset, duration, and severity of presenting concerns;

(d) Consumer/family expectations for recovery;

(e) Issues/concerns to be addressed in the consumer's treatment plan which warrant treatment and or management;

(f) Justification for treatment services and prognosis;

(g) For consumers with a diagnosed co-occurring substance use or abuse problem or condition the following shall also be included in the clinical formulation:

(A) Acute intoxication and/or withdrawal potential;

(B) Biomedical conditions or complications;

(C) Emotional/behavioral/cognitive conditions or complications;

(D) Readiness to change including treatment acceptance or resistance;

(E) Relapse/continued use potential; and

(F) Recovery environment and social supports.

(h) The mental health assessment shall be updated annually to include, at a minimum, the charges in the consumer's mental status, social support system, level of functioning, and shall document the consumer's participation in treatment planning.

(2) Treatment plan. An individualized treatment plan shall be developed no later than 45 calendar days after the date of initiation of services and include the following:

(a) Identify problems to be addressed based upon the needs identified in the mental health assessment and the consumer's readiness for treatment services;

(b) Include goals and objectives that are individualized, recovery-oriented, measurable, timely, and appropriate to the identified service needs;

(c) Specify the service regimen including:

(A) Services and activities to achieve identified goal(s) and objectives;

(B) Estimated frequency and duration of each service activity, or where flexible service delivery methods are identified as the treatment method of choice, a description of the flexible services to be provided to the consumer;

(C) The person(s) and/or program(s) who will be providing the service or activity;

(D) Documentation indicting the consumer and/or guardian (and family, where appropriate) was involved in treatment planning to the degree the consumer and/or guardian and family were capable of assisting;

(d) Documentation indicating that the treatment plan has been updated at least annually or in response to changes in the consumer's condition or relationships, such as changes in place of residence, employment status, divorce, homelessness, or improved or worsening symptomology.

(3) Progress notes shall meet the following requirements:

(a) A progress note shall be recorded and legible and signed by the person providing the service each time a service is provided and at any time a significant change occurs in the consumer's condition. However, a two week summary progress note may be done to record the delivery of Daily Structure and Support, and Skills Training, provided the number, dates of delivery, and time taken to provide the services are recorded;

(b) Each progress note shall specify the type of service(s) provided, the date provided, and the setting in which service was provided. Progress notes shall also document:

(A) Consumer/Family involvement in accomplishing goals as planned;

(B) Periodic discussions with the consumer concerning progress toward meeting goals identified in the treatment plan;

(C) Significant changes in the consumer's condition or functioning;

(D) Description of other significant problems or events as they occur and their effect on the consumer; and

(E) Contacts with other agencies providing services to the consumer or for the purpose of referral.

(4) Medical services. Medical services shall be provided and documented in a legible manner consistent with professional and community standards of care and shall include the following:

(a) Orders for medication, laboratory and other medical procedures shall be recorded in the clinical record in conformance with standard medical practice. Such orders, whether written or verbal, shall be initiated and authenticated by a LMP. Consultation and/or exchange of information with other medical personnel who are not employed by, or under contract to, the provider shall be documented in the clinical record.

(b) Written documentation of medications prescribed for the consumer by a LMP shall maintained in the clinical record. Documentation for each medication prescribed shall include the following:

(A) A copy or detailed written description of the signed prescription order;

(B) The name of medication prescribed;

(C) The prescribed dosage and method of administration;

(D) The date medications were prescribed, reviewed, or renewed;

(E) The date, the signature and credentials of staff administering and/or prescribing medications; and

(F) Medication use record which contain:

(i) Observed side effects including laboratory findings;

(ii) Medication allergies and adverse reaction; and

(iii) Documentation that the consumer was asked about possible adverse effects of medications, including sexual dysfunction, and evaluation for tardive dyskinesia when appropriate.

(5) A discharge summary shall include the following:

(a) Written documentation of the last service contact with the consumer, the diagnosis at admission and a summary statement that describes the effectiveness of treatment modalities and progress relative to goals listed in the treatment plan while in service;

(b) The reason(s) for discharge, changes in diagnosis during the course of treatment, current diagnosis and level of functioning, and prognosis and recommendations for further treatment. Discharge summaries shall be completed within 30 calendar days after a planned discharge and within 45 calendar days after an unplanned discharge.

(c) Consumer participation in planning for the termination of services and preparation to further his/her recovery.

(d) When participation in services is terminated for a consumer who no longer appears for services, the provider shall document efforts made to locate or contact the consumer, or document the reason why such efforts were not made.

Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0585
Service Supervision

Except as provided for by section (2) of this rule, any staff providing services to a consumer shall be supervised.

(1) Employees of programs certified in accordance with this rule and other contracted persons providing services to consumers shall receive supervision by a qualified supervisor in regard to the development and implementation of the treatment plan and in monitoring the effectiveness of services.

(2) Service supervision exceptions. Notwithstanding the supervision requirements above, the provider may modify the requirements specified in these rules for supervision of independent contractors who are QMHPs and are licensed under existing Oregon Revised Statutes to conduct independent practice without supervision.

Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0595
Quality Management Requirements

Providers shall develop and implement a planned, systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to adults. The quality management system shall include a quality management committee and a quality management plan which together implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based on input from other service providers and consumers.

(1) The quality management committee shall develop and implement the quality management plan and shall be a catalyst for improvement in the organization's clinical outcomes. The quality management committee shall be composed of:

(a) One or more QMHPs, including an LMP, who are representative of the scope of services delivered;

(b) A representative or representatives of the adults served. Additionally the organization shall invite and support representatives of family members of consumers to participate as members of the quality management committee;

(c) Other persons who have the ability to identify, design, measure, assess and implement clinical and organizational changes; and

(d) Other persons as deemed necessary to assure the provision of culturally competent and non-discriminatory service delivery.

(2) The quality management committee duties shall:

(a) Identify indicators of quality;

(b) Identify measurable and time-specific performance objectives;

(c) Identify data sources and methodology to measure performance;

(d) Develop a process to systematically collect outcome data and identify staff who will collect and analyze data;

(e) Oversee the data collection process;

(f) Analyze the information collected and measure progress toward performance objectives;

(g) Identify clinical and operational changes necessary to achieve performance objectives;

(h) Implement clinical or operational changes that are indicated by the achievement or non-achievement of performance objectives; and

(i) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis.

(3) The quality management committee shall meet at least quarterly.

(4) The written quality management plan shall describe the implementation and ongoing operation of the functions performed by the quality management committee. The quality management plan shall include:

(a) A description of the quality management committee's authority to identify and implement clinical and organizational changes;

(b) The composition and tenure of the quality management committee;

(c) The schedule of quality management committee meetings;

(d) The policies and procedures for identifying measurable performance objectives;

(e) The policy and procedures for identifying and using data sources;

(f) The indicators of quality in the following domains:

(A) Access to services;

(B) Quality of care;

(C) Integration and coordination; and

(D) Outreach and prevention.

(g) The policies and procedures for reporting, tracking, investigating, and analyzing reports of critical incidents;

(h) The policies and procedures for both reviewing documentation and determining that the staff have the required competencies and credentials to perform assigned duties and meet the provider's performance objectives;

(i) The policies and procedures to manage utilization of services;

(j) The policies and procedures for reviewing and responding to complaint and grievance information; and

(k) The policies and procedures for conducting clinical record reviews.

(5) A written summary of the pertinent facts and conclusions of each quality management committee meeting will be maintained and be available for review.

(6) The quality management committee shall evaluate the quality management plan at least annually and update the quality management plan as necessary.

Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

309-032-0605
Variances

(1) Criteria for a variance. Variances may be granted to a CMHP or provider if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The CMHP or provider requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the LMHA or designee recommending approval for the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office of Mental Health Services shall approve or deny the request for a variance.

(4) Notification. The Office of Mental Health Services shall notify the CMHP and/or provider in writing of the decision to approve or deny the requested variance. This notice shall be given to the CMHP and provider within 30 days of the receipt of the request by the Office of Mental Health Services.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The CMHP or provider may implement a variance only after written approval from the Division.

(7) Duration of variance. A variance to these rules shall be valid for a period of no more than two years. A variance may be reissued through written application for a variance from the CMHP or provider, as described above, and upon written approval by the Office of Mental Health Services.

Stat. Auth.: ORS 430.041 & 430.640
Stats. Implemented: ORS 426.490 - 426.500 & 430.630
Hist.: MHD 7-1992, f. & cert. ef. 9-30-92; MHD 6-2001, f. 7-26-01, cert. ef. 7-27-01

Standards for Enhanced Care Services

309-032-0720
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for the delivery of mental health services designed to treat eligible persons with severe mental illness residing in selected Senior and Disabled Services Division licensed facilities.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 430.640(1)(h) to carry out the provisions of ORS 426.490 through 426.500 and 430.630.

Stat. Auth.: ORS 426.500, 430.041, 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0730
Definitions

As used in these rules:

(1) "Activities" refers to rehabilitative services or recreational events developed by the treatment team to address a resident's needs.

(2) "Aids" refers to Certified Nursing Assistants in nursing homes and non-certified aides in residential care facilities who meet requirements set forth in section (14) of this rule.

(3) "Behavioral program" is a component of an individual treatment plan that addresses behavioral dysfunctions.

(4) "Care plan" refers to the individual plan developed by Senior and Disabled Services Division contractors under OAR 411-086-0060, Comprehensive Assessment and Care Plan. The care plan may reference or include the mental health treatment plan described in section (15) of this rule.

(5) "Client Process Monitoring System (CPMS)" means the automated client data system maintained by the Division.

(6) "Community mental health program (CMHP)" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Mental Health and Developmental Disability Services Division.

(7) "County of origin" means the county having psychiatric hospitalization responsibility for an individual prior to placement in the Enhanced Care Services program.

(8) "Day treatment" means direct mental health or rehabilitative services provided to the resident by CMHP staff as defined in the treatment plan.

(9) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services of the State of Oregon.

(10) "Enhanced Care Services (ECS)" means services which enable eligible residents in designated Senior and Disabled Services Division facilities to control or decrease identified behavior problems, manage psychiatric symptoms, and maintain, improve or minimize deterioration in their psycho-social and functional status.

(11) "Enhanced Care Services Coordinator" means a qualified mental health professional employed by the Division or its subcontractor who is responsible for providing administrative and clinical support to Senior and Disabled Services Division (SDSD) staff, SDSD providers, CMHP and hospital staff serving clients who receive Enhanced Care Services.

(12) "Mental health aide" is a qualified mental health associate or a designated certified nursing assistant who implements programs described in an individual treatment plan under the supervision of a QMHP.

(13) "Provider" means an organizational entity which is licensed by the Senior and Disabled Services Division and is responsible for the direct delivery of adult foster home, residential care or nursing facility services.

(14) "Qualified mental health associate (QMHA)" means a mental health staff with qualifications defined in OAR 309-016-0005(22), Medicaid Payment for Community Mental Health Services.

(15) "Qualified mental health professional (QMHP)" means a mental health practitioner employed by the Division or its subcontractor with qualifications defined in OAR 309-016-0005(23), Medicaid Payment for Community Mental Health Services.

(16) "Resident" as used in these rules means, an individual who resides in a Senior and Disabled Services facility and receives Enhanced Care Services.

(17) "Senior and Disabled Services Division (SDSD)" means the Department of Human Services agency responsible for the provision of community based care and nursing facility services to eligible persons as specified in OAR 411; division 50, Adult Foster Homes; division 55, Residential Care Facilities; division 65, Specialized Living Facilities; division 70, Title XIX Long-Term Care Facilities; division 85, Nursing Facilities, Generally; division 86, Administration and Services; division 87, Physical Environment; division 88, Transfer Rules; and division 89, Complaints, Inspection Sanctions.

(18) "Treatment plan" means the mental health plan developed by CMHP staff in conjunction with provider staff required by OAR 309-016-0005(28), Medicaid Payment for Community Mental Health Services. This plan will be included or referenced in the providers care plan, in section (3) of this rule.

(19) "Treatment team" means the resident or legal representative, supervising QMHP, nurse practitioner or physician providing psychiatric services, and QMHA or activities aide, who meet weekly with provider staff (section (10) of this rule) to coordinate and develop the treatment plan.

Stat. Auth.: ORS 426.500, 430.041 & 430.630
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0740
Services to be Provided

(1) Standards. Enhanced Care Services shall be provided consistent with OAR 309-016-0000 through 309-016-0130, Medicaid Payment for Community Mental Health Services.

(2) Services. Enhanced Care Services shall include:

(a) A day treatment program or an individualized treatment program supervised by a QMHP and offered either off-site or at the SDSD licensed facility;

(b) 12 hours-a-week of activities available during evening and weekend shifts provided or arranged by the CMHP staff;

(c) Weekly treatment team meetings to review behavior programs, develop treatment plans, and coordinate care planning with provider staff and related professionals;

(d) A crisis service staffed by a QMHP or the local CMHP available to the provider and direct care staff 24 hours a day;

(e) Quarterly mental health inservice trainings delivered to the provider and related personnel working with recipients of the Enhanced Care Services.

Stat. Auth.: ORS 426.500, 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0750
Staffing

The CMHP shall ensure, through development of contracts between the CMHP and provider, that staff time will be designated as follows:

(1) QMHP responsibilities. A QMHP to coordinate admissions, discharges and weekly treatment team meetings; develop resident assessment, treatment and behavioral plans; provide on-site supervision of QMHAs and to coordinate services and trainings with facility personnel.

(2) Psychiatric consultation. On-site psychiatric consultation by a nurse practitioner or physician to include attendance at weekly treatment team meetings.

(3) QMHA responsibilities. An on-site QMHA or mental health aide to coordinate or implement day treatment, activity and behavioral programs as specified in individual treatment plans.

(4) Aide responsibilities. Aide staff assigned 24 hours-a-day to implement activities programs, behavior plans and risk management procedures designated in individual treatment plans and unit policy and procedures.

Stat. Auth.: ORS 426.500, 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0760
Eligibility Requirements

(1) Screenings. In order to be eligible for Enhanced Care Services, a person shall be determined by SDSD staff to be eligible for a nursing facility or community-based care services as defined in OAR 411-015-0100 and be determined by either the Oregon State Hospital gero-psychiatric outreach team or the Enhanced Care Services Coordinator as appropriate for Enhanced Care Services.

(2) Symptoms. An eligible person must exhibit two or more of the following: Self endangering behaviors, aggressive behaviors, intrusive behaviors, intractable psychiatric symptoms, problematic medication needs, sexually inappropriate behaviors, or elopement behaviors.

(3) Placement history. An eligible person must have a history of failed community placements or a length of stay at a psychiatric hospital of greater than 30 days and be currently ineligible for placement in a nonenhanced setting.

Stat. Auth.: ORS 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0770
Admission Requirements

(1) Evaluation. All persons seeking Enhanced Care Services shall be evaluated by the CMHP provider and local SDSD staff prior to placement in a specific facility.

(2) Placement plan. The CMHPs and referring facility staff shall develop a 30 day consultation agreement and an alternative placement plan to be utilized in the event that the placement is unsuccessful.

(3) Release of information. All residents or their legal guardians shall be asked to sign a release of information form designating the Senior and Disabled Services Division and its licensed providers as recipients of treatment information.

(4) County of origin. The county of origin shall retain responsibility for public sector psychiatric inpatient services of residents receiving Enhanced Care Services.

Stat. Auth.: ORS 426.500 & 430.630
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0780
Discharge Requirements

(1) Notification. The CMHP shall notify the Division or its designee, within three working days, of any change in a resident's medical or psychiatric condition which jeopardizes the placement.

(2) Review. The Division or its designee shall review a permanent discharge of a resident prior to transfer or within three working days after an emergency transfer or hospitalization.

Stat. Auth.: ORS 426.500 & 430.630
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0790
Administrative Requirements

(1) Written agreements. The CMHP shall develop written agreements or contracts with providers which address: supervision of on-site CMHP and provider staff, risk management, census management, aide staffing levels, training, activities program, admission and discharge procedures, critical incidents, record keeping, developments of policy and procedure manuals and other service coordination issues.

(2) Team meetings. CMHP staff shall inform related professionals, such as SDSD case managers, the nurse or physician responsible for medical care, and the provider of all treatment team meetings and shall schedule meetings at times that encourage full participation.

(3) SDSD standards. All CMHP staff working in an SDSD licensed facility will comply with applicable requirements specified in OAR 309-032-0730(14).

(4) Data collection. The CMHP shall ensure that all persons receiving Enhanced Care Services are enrolled in the Division's Client Process Monitoring System (CPMS), and terminated when services are discontinued.

Stat. Auth.: ORS 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0800
Environment

A CMHP shall provide Enhanced Care Services in SDSD licensed facilities that provide a multipurpose room, an area for residents requiring an environment with low stimulation, an accessible outdoor space with a covered area, a refrigerator and microwave conveniently located for program activities, space for staff meetings, and mental health treatment and storage of records and security doors. A minimum of one private room will be required in facilities opened after January 1, 1994.

Stat. Auth.: ORS 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0810
Records

(1) Requirements. All Enhanced Care Services shall comply with OAR 309-016-0000 through 309-016-0130, Medicaid Payment for Community Mental Health Services; regarding documentation and record keeping.

(2) Confidentiality. CMHPs providing Enhanced Care Service shall comply with the confidentiality requirements of ORS 179.505 through 179.507, Inspection, Disclosure or Release of Patient Records by Provider.

(3) Documentation. Documentation of mental health services shall be kept in the resident's facility chart, shall be available to provider staff, and shall include the treatment plan and reviews, problem list, mental health assessment, psychiatric consultation notes, case notes and an annual review of the individual's need for a locked facility.

(4) Behavior programs. A treatment plan that addresses a behavioral dysfunction through the use of interventions such as but not limited to: soft restraints, chair devices, time out, personal holds, show of force, level systems or negative reinforcement shall include a behavioral program. The behavioral program shall:

(a) Analyze the behavior to be modified in order to develop a measurable description of the behavior which includes factors such as predictors, frequency, duration, intensity and severity;

(b) Include a description of procedures, including staff roles, which will be used in a consistent manner, to alter the problem behavior and reinforce alternative behavior;

(c) Include documentation that the resident and/or guardian and members of the treatment team are fully aware of and consent to the behavioral program;

(d) Emphasize the development of alternative behaviors, positive approaches and positive behavior intervention;

(e) Use the least restrictive intervention possible;

(f) Ensure that locked seclusion, locked restraints, abusive or demeaning intervention shall not be used; and

(g) Be evaluated by the treatment team through a weekly review of data that addresses progress toward measurable outcomes.

(5) Record access. The CMHP will ensure through agreement with providers, that staff of the CMHP shall have access to relevant resident records including medication sheets, doctor's orders, lab reports, assessments and care plans.

Stat. Auth.: ORS 430.041, 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0820
Rights

Enhanced Care Services shall operate under standards specified in OAR 309-016-0000 through 309-016-0130, Medicaid Payment for Community Mental Health Services.

Stat. Auth.: ORS 430.630 & 430.640(1)(h)
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

309-032-0830
Variances

A variance from these rules may be granted to an agency in the following manner:

(1) Description. An agency requesting a variance shall submit, in writing, through the community mental health program to the appropriate program or administrative office:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the local mental health authority indicating its support of the proposed variance.

(2) Review. The assistant administrator of the program or administrative office shall approve or deny the request for variance.

(3) Notification. The program or administrative office shall notify the community mental health program of the decision. The community mental health program shall forward the decision and reasons therefore to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the program or administrative office with a copy to other relevant sections of the Division and SDSD.

(4) Appeal. Appeals of the denial of a variance request shall be to the Administrator of the Division, whose decision shall be final.

(5) Duration. A variance granted by the Division shall be attached to, and become part of, the Intergovernmental Agreement for that year.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1995, f. & cert. ef. 4-6-95

Community Treatment and Support Services

309-032-0850
Standards for Regional Acute Care Psychiatric Services for Adults

(1) Purpose: These rules prescribe standards and procedures for regional acute care psychiatric services for adults.

(2) Statutory Authority: These rules are authorized by ORS 430.041 and 430.640(1)(h) to carry out the provisions of ORS 426.490 through 426.500 and 430.630(3).

Stat. Auth.: ORS 426.490 - 426.500 & 430.630(3)
Stats. Implemented:
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0860
Definitions

As used in these rules:

(l) "Adult" means a person age 18 years or older.

(2) "Clinical record" means a separate file established and maintained under these rules for each patient.

(3) "Community mental health program" or "CMHP" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the Mental Health and Developmental Disability Services Division.

(4) "Council" means an organization of persons, with a mission statement and by-laws, comprised of representatives of the regional acute care psychiatric service, state hospital, community mental health programs served, consumers, and family members. The Council is advisory to the regional acute care facility for adults.

(5) "Diagnosis" means a DSM diagnosis determined through the mental health assessment and any examinations, laboratory, medical or psychological tests, procedures, or consultations suggested by the assessment.

(6) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(7) "DSM" means the current edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.

(8) "Goal" means the broad aspirations or outcomes toward which the patient is striving, and toward which all services are intended to assist the patient.

(9) "Guardian" means a person appointed by a court of law to act as a guardian of a legally incapacitated person.

(10) "Independent medical practitioner" means a medically trained person who is licensed to practice independently in the State of Oregon and has one of the following degrees: MD (Medical Doctor), DO (Doctor of Osteopathy), or NP (Nurse Practitioner).

(11) "Legally incapacitated" means having been found by a court of law under ORS 126.103 or 426.295 to be unable, without assistance, to properly manage or take care of one's personal affairs.

(12) "Linkage agreement" means a written agreement between the regional acute care psychiatric services, the local community mental health programs, and state hospitals which describes the roles and responsibilities each assumes in order to assure that the goals of the regional acute care psychiatric services are achieved.

(13) "Medical director" means a board eligible psychiatrist who oversees the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(14) "Medical history" means a review of the patient's current and past state of health as reported by the patient or other reliable sources, including, but not limited to:

(a) History of any significant illnesses, injuries, allergies, or drug sensitivities; and

(b) History of any significant medical treatments, including hospitalizations and major medical procedures.

(15) "Mental health assessment" means a process in which the person's need for mental health services is determined through evaluation of the patient's strengths, goals, needs, and current level of functioning.

(16) "Mental status examination" means an overall assessment of a person's mental functioning that includes descriptions of appearance, behavior, speech, mood and affect, suicidal/homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, memory, concentration, general knowledge, abstraction abilities, judgment, and insight.

(17) "Objective" means an interim level of progress or a component step the specification of which is necessary or helpful in moving toward a goal.

(18) "Office" means the Office of Mental Health Services of the Mental Health and Developmental Disability Services Division.

(19) "OPRCS" means the Oregon Patient/Resident Care System. OPRCS is a Division operated, on-line computerized information system which accepts, stores and returns information about patients from state operated institutions and other designated inpatient services.

(20) "Patient" means a person who is receiving care and treatment in a regional acute care psychiatric service.

(21) "Person committed to the Division" means a patient committed under ORS 161.327 or 426.130.

(22) "Program administrator" means a person, with appropriate professional qualifications and experience, appointed by the governing body to manage the operation of the regional acute care psychiatric services.

(23) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(24) "Qualified mental health professional" or "QMHP" means a person who is one of the following:

(a) Psychiatrist or physician, licensed to practice in the State of Oregon; an individual with a graduate degree in psychology, social work, or other mental health related field; a registered nurse with a graduate degree in psychiatric nursing, licensed in the State of Oregon; an individual with registration as an occupational therapist; an individual with a graduate degree in recreational therapy; or

(b) Any other person whose education, experience, and competence have been documented by the CMHP director or designee as able to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social, and work relationships, conduct a mental status assessment; document a DSM diagnosis; write and supervise a rehabilitation plan; and provide individual, family, and/or group therapy.

(25) "Regional acute care psychiatric service" or "service" means a Division funded service provided under contract with the Division or county, and operated in cooperation with a regional or local council. A regional acute care psychiatric service must include 24 hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 and older with severe psychiatric disabilities in a designated region of the State. For the purpose of these rules, a state hospital is not a regional acute care psychiatric service. The goal of a regional acute care service is the stabilization, control and/or amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the person to a less restrictive environment.

(26) "Supervisor" means a person who has two years of experience as a qualified mental health professional and who, in accordance with Section 309-032-0870 of these rules, reviews the services provided to patients by qualified persons.

(27) "Treatment plan" means an individualized, written plan defining specific rehabilitation objectives and proposed service interventions derived from the patient's mental health assessment.

Stat. Auth.: ORS 430.630(3)
Stats. Implemented:
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0870
Standards for Approval of Regional Acute Care Psychiatric Service

(1) State approvals and licenses. The facility in which a regional acute care psychiatric service is provided shall maintain state approvals and licenses as required by Oregon law for the health, safety, and welfare of the persons served. Non-hospital facilities shall be licensed by the Division as required by ORS 443.410. The facility must also be approved under OAR 309-033-0530 Approval of Hospitals and Nonhospital Facilities that Provide Services to Committed Persons and to Persons in Custody or on Diversion and OAR 309-033-0540, Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons in Custody, Psychiatric Hold or Certified for 14 Days of Intensive Treatment.

(2) Clinical record management. A regional acute care psychiatric service shall maintain clinical records as follows:

(a) Clinical records are confidential, as set forth in ORS 179.505 and 192.502 and any other applicable state or federal law, except as otherwise indicated by applicable rule or law. For the purposes of disclosure from non-medical individual records, both the general prohibition against disclosure of "information of a personal nature" and limitations to the prohibition in ORS 192.502(2) shall be applicable.

(b) Clinical records shall be secured, safeguarded, stored, and retained in accordance with OAR 166-030-1015.

(c) Clinical record entries required by these rules must be signed by the staff providing the service and making the entry. Each signature

must include the person's academic degree or professional status and the date signed.

(3) Clinical record content. The clinical record shall contain:

(a) Identifying demographic information, including, if available, who to contact in an emergency and the names of persons who encompass the support system of the patient.

(b) Consent to release information and explanation of fee policies. At the time of admission staff shall present the patient with forms for obtaining consent so that information may be shared with family and others. An explanation of fee policies shall also be provided in written form at the earliest time possible. The patient shall be asked to sign each. If the patient is unwilling or unable to sign, staff shall record that the person is unable or unwilling to do so.

(c) Admitting mental health assessment. An admitting mental health assessment shall be completed, by or under the supervision of an independent medical practitioner with supervised training or experience in a mental health related setting, within 24 hours of admission. The admitting mental health assessment shall include a description of the presenting problem(s), a mental status examination, an initial DSM diagnosis, and an assessment of the resources currently available to the person. The assessment shall result in a plan for the initial services to be provided. The admitting mental health assessment shall also include documentation that a medical history and physical examination of the person has been performed within 24 hours after admission by a physician, physician assistant, or nurse practitioner. If the independent medical practitioner believes a new medical history and physical examination are not necessary, and if within 30 days of admission a complete physical history has been recorded and a complete physical examination has been performed, the signed report of the history and examination may be placed in the clinical record and may be considered to constitute an appropriate physical health assessment.

(d) Psycho-social assessment. A psycho-social assessment shall be completed for each patient within 72 hours of admission. If the patient stays less than 72 hours, a psycho-social assessment need not be written. The assessment must be completed by a qualified mental health professional or supervisor. The assessment does not need to be a single document but must include the following elements:

(A) A description of events precipitating admission and any goal(s) of the patient in seeking or entering services.

(B) When relevant to the patient's service needs, historical information including: mental health history; medical history; substance use and abuse history; developmental history; social history, including family and interpersonal history; sexual and other abuse history; educational, vocational, employment history; and legal history.

(C) An identification of the patient's need for assistance in maintaining financial support, employment, housing, and other support needs.

(D) Recommendations for discharge planning and any additional services, interventions, additional examinations, tests, and evaluations that are needed.

(e) Treatment plan. A treatment plan, individually developed with the patient from the findings of the admitting mental health assessment and psycho-social assessment, must be completed by a QMHP or supervisor within 72 hours of the person's admission. The plan must be written at a level of specificity that will permit its subsequent implementation to be efficiently monitored and reviewed. The recorded plan shall contain the following components:

(A) The rehabilitation and other goals, including those articulated by the patient.

(B) Specific objectives, including discharge objectives, and the measurable or observable criteria for determining when each objective is attained;

(C) Specific services to be used to achieve each objective;

(D) The projected frequency and duration of services;

(E) Identification of the QMHP or supervisor assigned to the patient who is responsible for coordinating services;

(F) The signature of the patient indicating he/she has participated in the development of the plan to the degree possible. If the patient is unwilling or unable to sign the plan, staff shall record on the plan that the patient is unable or unwilling to do so.

(G) The plan must be reviewed weekly and updated with the participation of the patient when needed to reflect significant changes in the patient's status, and when significant new goals are identified.

(f) Progress notes. Progress notes shall document observations, treatment rendered. response to treatment, and changes in the patient's condition, and other significant information relating to the patient. All entries involving subjective interpretation of the patient's progress shall be supplemented by a description of the actual behavior observed.

(g) Reports of medication administration, medical treatments, and diagnostic procedures.

(h) Telephone communications about the patient, releases of information, and reports from other sources.

(i) The record shall contain medical and mental health advance directives or note that the patient has been provided this information.

(j) The record shall contain documentation that the person has been provided information on patient rights, grievance procedure, and abuse reporting.

(k) The record shall contain documentation including physician's orders and reasons for all restraint and seclusion episodes.

(l) Discharge plan. The discharge planning shall begin at the time of admission with the participation of the patient and, when indicated, the family, guardian and significant others. The discharge plan shall include the results of the admitting mental health assessment; DSM diagnoses; summary of the course of treatment, including prescribed medications; final assessment of the person's condition; recommendations and arrangements for further treatment including prescribed medications and continuing care; and documentation of the planning for, and securing of appropriate living arrangements.

(4) Patient data management. The regional acute care psychiatric service shall supply to the Division, using the Division's on-line Oregon Patient/Resident Client System (OPRCS), via computer and modem, information about persons admitted to and discharged from the service. Such information shall include the patient's name, DSM diagnosis, admission date, discharge date, legal status, Medicaid eligibility, Medicaid Prime Number and various patient demographics. Such information shall be entered on the day of admission and updated on the day of discharge.

(5) Professional staff standards. The regional acute care psychiatric service shall:

(a) Have sufficient appropriately qualified professional, administrative and support staff to assess and address the identified clinical needs of persons served, provide needed services, and coordinate the services provided.

(b) Designate a program administrator to oversee the administration of the services and carry out these rules.

(c) Designate a medical director to oversee the patient care program. The medical director shall have the final authority concerning inpatient medical care including admissions, continuing care, and discharges.

(d) Designate an individual responsible for maintaining, controlling and supervising medical records and be responsible for maintaining the quality of clinical records.

(e) Designate an individual responsible for the development, implementation and monitoring of a written safety management plan and program, who shall keep records of identified concerns and problems and actions taken to resolve them.

(f) Designate an individual responsible for the development, implementation and monitoring of a written infection control plan and program, who shall keep records of identified concerns and problems and action taken to resolve them.

(g) Designate, or contract with, a licensed pharmacist to be responsible for the development of pharmacy policies and procedures, and to assure that the service adheres to standards of practice and applicable state and federal laws and regulations.

(h) Maintain a schedule of unit staffing which shall be readily available to the Division for a period of at least the three previous years.

(i) Have on duty at least one registered nurse at all times.

(j) Maintain a personnel file for each patient care staff which includes a written job description; the minimum level of education or training required for the position; copies of applicable licenses, certifications, or degrees granted; annual performance appraisals; a biennial, individualized staff development plan signed by the staff; documentation of CPR training; documentation of annual training and certification in managing aggressive behavior, including seclusion and restraint; and other staff development and/or skill training received.

(k) A physician must be available, at least on-call, at all times.

(6) Policies and procedures manual. The regional acute care psychiatric service shall have a policy and procedure manual. The policy and procedure manual must be made available to any person upon request. The manual shall describe:

(a) The following policies and procedures:

(A) Governance and management, including: a table of organization describing the agency structure and lines of authority; a plan for professional services; and a plan for financial management and accountability.

(B) Procedures for the management of disasters, fire, and other emergencies.

(C) Policies and procedures required under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion addressing seclusion and restraint.

(D) Patient rights, including informed consent, access to records, and grievance procedure. The manual shall assure rights guaranteed by ORS 426.380 to 426.395 for committed persons and ORS 430.205 to 430.210 for those not committed. The grievance procedure must be in writing and include written responses, time limits for responses, use of a neutral party and a method of appeal. Programs shall post copies of the rights and grievance procedures in places accessible to all persons. Programs shall provide written copies of the rights and grievance procedure upon request.

(E) Abuse reporting for mentally ill or developmentally disabled as required by ORS 430.735 through 430.765, and 179.040, and OAR 309-040-0200 through 309-040-0290, Abuse Reporting and Protective Services in Community Programs and Community Facilities.

(F) Clinical record content and management policies and procedures, including the requirements of these rules.

(G) Psychiatric, medical, and dental emergency services policies and procedures.

(H) Pharmacy services policies and procedures approved by a licensed pharmacist.

(I) Quality assessment and improvement processes.

(J) Procedures for documenting privileges granted by the service in personnel records or other records.

(K) Policies and procedures for transfer of patients to other hospitals.

(b) The following policies and procedures, developed and amended in consultation with the council:

(A) Patient admission and discharge criteria. Unless the service has a policy and procedure recommended by the council and approved by the Division, the service shall only admit persons age 18 and older.

(B) Quality assessment and improvement processes relating to regional admissions and discharges.

(C) Patient admission, discharge and aftercare planning; including scheduling and planning for transportation of patients to the service by the referring county and from the service to the county of residence.

(D) Procedures for admission and discharge of geropsychiatric patients and persons with physical disabilities, including designation of a county or regional geropsychiatric liaison staff member.

(E) Linkage agreements with community mental health programs it serves and state hospitals.

(F) Medical and emergency care procedures, approved by the Division.

(G) Criteria for accepting pre-admission medical screening.

(H) Billing and collecting reimbursement from patients and third-party payors.

(7) Holding allegedly mentally ill persons. The service shall have an adequate number of hold rooms but at least one holding room and hold a current Certificate of Approval to hold and treat persons who are alleged to be mentally ill under OAR 309-033-0500 through 309-033-0540, Approval of Hospital and Nonhospital Facilities that Provide Services to Committed Persons or to Persons in Custody or on Diversion.

(8) Federal rules and regulations. The facility in which a service is operated shall comply with all applicable federal rules and regulations.

(9) Medical care. If the facility in which the regional acute care psychiatric service is operated is not in a general hospital, it shall have a letter of agreement with a general hospital for both emergency and medical care, which shall be renewed every two years.

(10) Quality assessment and improvement. The regional acute care psychiatric service shall have an ongoing quality assessment and improvement program to objectively and systematically monitor and evaluate the quality of care provided to patients served, pursue opportunities to improve care and correct identified problems. The program shall include:

(a) Policies and procedures that describes the quality assessment and improvement program's objectives, organization, scope, and mechanisms for improving services.

(b) A written annual plan to monitor and evaluate services. The written plan shall result in reports of findings, conclusions, and recommendations. Reports shall address:

(A) The care of patients served, including admission and discharge planning;

(B) Resource utilization, including the appropriateness and clinical necessity of admissions and continued stay, services provided, staffing levels, space, and support services;

(C) Quality and content of clinical records;

(D) Medication usage, including records, adverse reactions, and medication errors;

(E) Accidents, injuries, safety of patients, and safety hazards; and

(F) Uses of seclusion and restraint.

(c) A report to the governing board and council, at least annually, addressing:

(A) Findings and conclusions from studies;

(B) Recommendations, action taken, and results of the action taken; and

(C) An assessment of the effectiveness of the quality assessment and improvement program; including a review of the program's objectives, scope, organization and effectiveness.

(11) Council. The regional acute care psychiatric service shall have a council to ensure appropriate and effective care and treatment. The council shall meet to assess and collaboratively plan for improving care and treatment to patients, including patient transitions into and out of the service.

Stat. Auth.: ORS 179.010, 179.505, 192.502, 426.380 - 395, 426.490 - 500, 430.041, 430.205 - 210, 430.630(3) & 443.410
Stats. Implemented:
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

309-032-0890
Variances

(1) Criteria for a variance. Variances may be granted to a regional acute care psychiatric service if implementation of the proposed alternative services, methods, concepts or procedures would result in service or system that meet or exceeds the standards in these rules.

(2) Variance application. The service requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the regional acute care psychiatric service of the decision. This notice shall be given to the service, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The regional acute care psychiatric service may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.490 - 426.500 & 430.630(3)
Stats. Implemented:
Hist. MHD 8-1994, f. & cert. ef. 11-28-94

Alternatives to State Hospitalization
Standards for Community Treatment Services for Children

309-032-0950
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for community mental health treatment services for children within a comprehensive system of care. The system of care shall be child-centered and community-based with the needs of the child and family dictating the types and mix of services provided. These services may be as intensive, frequent and individualized as is medically necessary to sustain the child in treatment in the community. The provision of community mental health treatment services may require the treatment provider to work outside the clinic setting.

(2) Statutory Authority. These rules are authorized by ORS 430.041, 743.556 and 430.640(1)(h) to carry out the provisions of ORS 430.630.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-0960
Definitions

As used in these rules:

(1) "Admission criteria" means the standards to be met for a child to be enrolled in and receive community treatment services.

(2) "Biopsychosocial" means the combination of biological, psychological and sociocultural factors that influence the child's development and/or functioning.

(3) "Case number" means the unique identification number assigned to each child. No more than one such number shall be assigned to the child and the number shall be identical for both the treatment record and Client Process Monitoring System enrollment. Once assigned, the case number must be retained for all subsequent admissions or periods of service for the child.

(4) "Child" or "Children" means a person or persons under the age of 18, or for those with Medicaid eligibility, under the age of 21.

(5) "Children's Global Assessment Scale" or "CGAS" means a scale used to measure and condense different aspects of a child's biopsychosocial functioning into a single clinically meaningful index of severity. The CGAS is an adaptation of the Diagnostic and Statistical Manual Global Assessment Scale for adults by the Department of Child Psychiatry, Columbia University, published in November 1982. The CGAS is recommended for use with children aged 4 through 16. The CGAS score is numerically quantified on Axis Five of the DSM multiaxial diagnosis.

(6) "Client Process Monitoring System" or "CPMS" means an automated data system maintained by the MHDDSD.

(7) "Clinical record" means the collection of all documentation regarding a child's mental health treatment. The record is a legal document. The clinical record provides the basis by which the provider manages service delivery and quality assurance.

(8) "Clinical services coordination" means coordinating the access to, and provision of, services from multiple agencies according to the child's treatment plan; establishing crisis service linkages; advocating for the child's treatment needs; and providing assistance in obtaining entitlements based on a mental or emotional disability. To be eligible for Clinical Services Coordination, the enrolled child:

(a) Must have a severe and persistent mental disorder, which is not the result of conduct, substance abuse or mental retardation or other developmental disability, diagnosed on Axis I of a 5-Axes diagnosis;

(b) Must have documented mental or emotional symptoms that have been evident for one year or more, or are likely to continue for more than a year;

(c) Must have symptoms which have resulted in substantial functional limitations on two or more of the following areas of age appropriate development: role and task performance; cognition and communication; behavior toward self and others; and mood and emotions;

(d) Must have symptoms which result in a level of functioning of 49 or lower as scored on the CGAS or Global Assessment of Functioning Scale (GAF); and

(e) Must be at immediate risk of removal from home for mental health treatment or is returning home from a psychiatric inpatient or JCAHO accredited residential psychiatric treatment program.

(9) "Clinical supervision" means the documented oversight by a Qualified Mental Health Professional of mental health treatment services provided by a Qualified Mental Health Professional or Qualified Mental Health Associate. Clinical Supervision includes evaluating the effectiveness of the mental health treatment services provided. Clinical Supervision is performed on a regular, routine basis either individually or in a group setting at least once every three months.

(10) "Clinical supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting who follows a professional code of ethics. The Clinical Supervisor, as documented by the Local Mental Health Authority, demonstrates the competency to oversee and evaluate the mental health treatment services provided by the Qualified Mental Health Professional or Qualified Mental Health Associate.

(11) "Community crisis services" means a system of urgent and emergency services of limited duration including screening, mental health assessment, and stabilization provided by every CMHP or its designated subcontractors 24 hours-a-day, seven days-a-week to respond to, and stabilize, children in mental health crisis.

(12) "Community Mental Health Program" or "CMHP" means the entity providing the services described in ORS 430.620 and 430.630(3) for persons with mental or emotional disorders, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, and operated in a specific geographic area of the state under an omnibus contract with the MHDDSD.

(13) "Community treatment services" means the full range of children's mental health services, except inpatient care, defined in ORS 430.630(3) and 743.556.

(14) "Comprehensive mental health assessment" means a mental status exam and a biopsychosocial evaluation of a child's functioning in the following domains: emotional, cognitive, family, developmental, behavioral, social, physical, nutritional, school or vocational, substance abuse, cultural and legal, completed by a Qualified Mental Health Professional. The Comprehensive Mental Health Assessment concludes with a completed DSM five axes diagnosis followed by a clinical formulation and a comprehensive treatment plan. The Comprehensive Mental Health Assessment is revised and updated annually.

(15) "Consent to treatment" means the written agreement between the child's custodial parent or guardian, or by the child if age 14 or older, and the provider of mental health services, for the child to receive community mental health treatment services.

(16) "Consultation" is the planned professional advice about an enrolled child given by the Qualified Mental Health Professional to another professional involved in the child's treatment. Consultation is specific to goals and objectives in the child's treatment plan and is documented in the progress notes.

(17) "Continued stay criteria" means the standards to be met for a child to remain in community mental health treatment.

(18) "Crisis" means either an urgent or emergency situation that occurs when a child's mental or emotional stability or functioning is disturbed by a critical event in the child's environment and there is an immediate need to resolve the situation to prevent a serious deterioration in the child's condition.

(19) "Crisis stabilization" means the provision of appropriate child and family, psychological, and psychiatric and other medical interventions in the most normative setting possible for the child, and any placements necessary to protect and stabilize the child as quickly as possible.

(20) "Critical incident" means an incident as a result of staff action or inaction that punishes, endangers or otherwise harms a child enrolled in a community mental health program service.

(21) "Custodial parent" means the parent or parents having legal custody of the child.

(22) "Custody" means the legal care and supervision of the child by the person, agency or institution having the authority to authorize ordinary medical, psychiatric, psychological and other remedial care and treatment for the child. Under ORS 418.312, custodial parents are

not required to transfer legal custody of a child to the State Office for Services to Children and Families (SCF) in order to have the child placed in an SCF-contracted foster home, group home, residential or other institutional child care setting when the sole reason for the placement is the need to obtain services for the child's emotional, behavioral or mental disorder.

(23) "Diagnosis" means the principal mental disorder listed in the DSM, that is the medically necessary reason for clinical care and the main focus of treatment. The principal diagnosis is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment. A DSM "V" code condition, substance use disorder or mental retardation is not considered the principal diagnosis although these conditions or disorders may co-occur with the diagnosable mental disorder.

(24) "Direct supervision" means the directing and coordinating by the QMHP of interventions performed by the Qualified Mental Health Associate (QMHA). Direct supervision also means reviewing and evaluating the documentation of all interventions performed by the QMHA. Direct supervision is performed on a regular, routine basis either individually or in a group setting.

(25) "Discharge criteria" means the standards to be met to complete service provision.

(26) "Discharge summary" means written documentation of the last service contact with the child, the diagnosis at enrollment, a summary statement that describes the effectiveness of treatment modalities and progress, or lack of progress, toward treatment objectives while in service. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning and prognosis and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.

(27) "DSM" means the fourth edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.

(28) "Early and Periodic Screening, Diagnosis and Treatment" or "EPSDT" means the preventive and remedial medical care program for eligible persons under 21 years of age who are enrolled in the state's Medicaid program.

(29) "Emergency" means the sudden onset of acute psychiatric symptoms requiring attention within 24 hours to prevent a serious deterioration in a child's mental condition.

(30) "Enrollment" means, for a CMHP or CMHP subcontractor, the act of opening a clinical record for a child who is not currently receiving services. The date of enrollment is the first face to face treatment session with the child or the child's family. Enrollment documentation includes the completed CPMS enrollment form. For children eligible to receive services from a Fully Capitated Health Plan or Mental Health Organization, enrollment means signing on with a fully capitated health plan or mental health organization under contract with the MHDDSD.

(31) "Five axes diagnosis" means the multiaxial system of evaluation in the DSM organized to provide a biopsychosocial approach to assessment and to ascertain that all of the information necessary for planning treatment and predicting outcomes for the child is recorded on each of five axes. The principal diagnosis is recorded on Axis I, any description of mental retardation or personality features on Axis II, physical disorders or conditions on Axis III, severity of psychosocial stressors on Axis IV, and the global assessment of functioning on Axis V.

(32) "Fully Capitated Health Plan" or "FCHP" means a prepaid health plan under contract with the MHDDSD and Office of Medical Assistance Programs to provide capitated physical and mental health services.

(33) "Global Assessment of Functioning Scale" or "GAF" means a scale in the DSM used to measure and condense different aspects of biopsychosocial functioning in adolescents 17 and older and adults into a single clinically meaningful index of severity of disorder. The GAF score is numerically quantified on Axis Five of the DSM multiaxial diagnosis.

(34) "Goal" means an expected result or condition to be achieved, is specified in a statement of relatively broad scope, provides a guideline for the direction of care and is related to an identified clinical problem.

(35) "Guardian" means a parent, other person or agency legally in charge of the affairs of a minor child and having the authority to make decisions of substantial legal significance concerning the child.

(36) "Informed consent to treatment" means that the information about a specific diagnosis and the risks or benefits of treatment options and the consequences of not receiving a specific treatment are understood by the child, if able, and the parent or guardian, if involved. The person consenting to treatment voluntarily agrees in writing, as required in ORS 430.210(d), to a prescribed treatment for the specific diagnosis.

(37) "Level of care" means the range of available mental health services provided from the least restrictive and least intensive in a community-based setting to the most restrictive and most intensive in an inpatient setting. As required in ORS 430.210(a), children are to be served in the most normative, least restrictive, least intrusive level of care appropriate to their treatment history, degree of impairment, current symptoms and the extent of family or other supports.

(38) "Level of functioning" means the description and numeric quantification on Axis V of a DSM diagnosis of the effectiveness of a child's ability to achieve or maintain developmentally appropriate behavior in one or more of the following areas: role and task performance, cognition and communication, behavior toward self and others, and mood and emotions as measured against age appropriate norms.

(39) "Licensed Medical Practitioner" means any person who meets the following minimum qualifications as documented by the Local Mental Health Authority or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon;

(C) Physician's Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(c) When the LMP is not a psychiatrist, the LMP shall have access to consultation services provided by a psychiatrist, preferably a child psychiatrist, either through direct employment by the provider or through written contract between the provider and the consulting psychiatrist.

(40) "Local Mental Health Authority" or "LMHA" means the county court or board of county commissioners of one or more counties who choose to operate a county mental health program or choose to operate an MHO; or, in the case of a Native American reservation, the tribal council; or, if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation which contracts with the MHDDSD to operate a CMHP or MHO for that county.

(41) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to poor and indigent persons. Medical assistance programs cover both health and mental health care for children and adults. Some services, such as EPSDT, are required to be provided by the state. Other services, such as case management, are optional.

(42) "Medicaid Authorization Specialist" or "MAS" means the Qualified Mental Health Professional designated at the county or regional level to determine the mental health needs of children requesting services, or for whom services are requested, and to authorize the provision of mental health services identified in the Service Authorization Form for Medicaid-eligible children.

(43) "Medical necessity" means the determination by a Licensed Medical Practitioner operating within the scope of his or her license, training and experience, that a service is reasonably necessary to diagnose, correct, cure, alleviate, rehabilitate or prevent the worsening of a disabling mental disorder. Medically necessary services must be consistent with standards of good practice, generally recognized by the professional community as effective, and there must also be no other equally effective, more conservative, or less costly course of treatment available or suitable for the person requesting the service.

(44) "Medication service record" means the documentation of written or verbal orders for medication, laboratory, and other medical procedures issued by a Licensed Medical Practitioner employed by, or under contract with, the provider and acting within the scope of his

or her license. The provision of medication services is documented in written progress notes and placed in the client's record.

(45) "Mental Health and Developmental Disability Services Division" or "MHDDSD" means the Department of Human Services Agency responsible for the administration of state mental health and developmental disabilities programs and the mental health and developmental disabilities laws of the state.

(46) "Mental health assessment" means the documentation by a QMHP of the child's presenting mental health problem(s) and relevant child and family history, mental status examination and DSM five axis diagnosis or provisional diagnosis.

(47) "Mental Health Organization" or "MHO" means an entity under a risk bearing contract with the MHDDSD to provide mental health services on a prepaid, capitated basis.

(48) "Mental status examination" means the face-to-face assessment by a QMHP of a child's mental functioning within a developmental and cultural context that includes descriptions of appearance, behavior, speech, language, mood and affect, suicidal or homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, concentration, general knowledge, intellectual ability, abstraction abilities, judgment, and insight appropriate to the age of the child.

(49) "Minor child" means an unmarried person under the age of 18.

(50) "Non-custodial parent" means a parent whose custodial responsibilities have been removed by the court by divorce decree. Under ORS 107.154, and unless otherwise ordered by the court, non-custodial parents have the same rights to consult with any person who may provide care and treatment for the child and to inspect and receive the child's medical and psychological records to the same extent as the custodial parent. The non-custodial parent may also authorize emergency medical, psychological and psychiatric or other health care if the custodial parent is unavailable.

(51) "Nurse Practitioner" means a Registered Nurse who has a graduate degree in nursing and is certified by the Oregon State Board of Nursing as qualified to practice as a Psychiatric/Mental Health Nurse Practitioner.

(52) "Objective" means the written statement of an expected result or condition that is related to the attainment of a goal. The objective is stated in measurable terms, has a specified time for accomplishment, and describes what services or activities are needed, how frequently they are needed and the primary Qualified Mental Health Professional who will be coordinating them.

(53) "Physician" means a Medical Doctor or a Doctor of Osteopathy licensed to practice in Oregon. For these rules, a physician is preferably a Board-Certified Child Psychiatrist.

(54) "Plan of correction" means a written document which specifies actions that a provider will take to come into compliance with these rules.

(55) "Progress note" means the written documentation of the clinical course of treatment. Progress notes become the basis for review and revision of the treatment plan and the treatment provided. Progress notes shall document the specific treatment service rendered, the child's response to the specific treatment service, the date the service was provided, the setting, who performed the service, who was present, and the amount of time taken to provide the service. A progress note concludes with the signature, educational credentials of the person providing the service, and the date the note was signed.

(56) "Provider" means a CMHP, CMHP subcontractor, FCHP or MHO which is contractually affiliated with the MHDDSD and is responsible for the direct delivery of children's mental health services, or an agency providing services under ORS 743.556.

(57) "Provisional diagnosis" means a statement on Axis I of a DSM diagnosis when there is a strong presumption that the full criteria for the diagnosis will ultimately be met.

(58) "Psychiatrist" means a physician who is Board-Eligible or Board-Certified in psychiatry and licensed in the State of Oregon.

(59) "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the direct supervision of a Qualified Mental Health Professional and who meets the following minimum qualifications as documented by the Local Mental Health Authority or designee:

(a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three years work, education, training or experience; and

(b) Has the competencies necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts;

(C) Provide psychosocial skills development; and

(D) Implement interventions prescribed on a treatment plan.

(60) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner or any other person who meets the following minimum qualifications as documented by the Local Mental Health Authority or designee:

(a) Holds any of the following educational degrees:

(A) Graduate degree in psychology;

(B) Bachelor's degree in nursing and licensed by the State of Oregon;

(C) Graduate degree in social work;

(D) Graduate degree in a behavioral science field;

(E) Graduate degree in recreational, music, or art therapy;

(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(b) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a treatment plan; conduct a Comprehensive Mental Health Assessment and provide individual, family and/or group therapy within the scope of their training.

(61) "Quality assurance" means the structured, internal monitoring and evaluation process to:

(a) Identify aspects of quality care;

(b) Use indicators and clinical criteria to continually and systematically monitor these aspects of care;

(c) Establish markers which indicate problems or opportunities to improve care;

(d) Take action to correct problems and improve substandard care;

(e) Assess the effectiveness of the actions; and

(f) Document the improvements in care.

(62) "Service coordination plan" means the written record of the services provided for children with a severe and persistent mental disorder by the social service agencies serving the child.

(63) "Severe and persistent disorder" means an emotional, mental, and/or neurobiological impairment which is manifested by emotional or behavioral symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism and which continues for more than one year, or on the basis of a specific diagnosis is likely to continue for more than one year.

(64) "Setting" means the location at which community-based mental health treatment services are provided and includes the CMHP office, the child's residence or other identified location.

(65) "Substantial compliance" means a level of adherence to MHDDSD rules applicable to the operation of a service that warrants certification by the MHDDSD as set forth in OAR 309-012-0000 through 309-012-0220.

(66) "System of care" means the comprehensive array of mental health and other necessary services which are organized to meet the multiple and changing needs of children with mental disorders.

(67) "Treatment" means the planned, medically necessary, individualized program of medical, psychological, and/or rehabilitative procedures, experiences and activities for a child designed to remediate symptoms of a principal mental or emotional disorder diagnosed on Axis I of a five-axes DSM diagnosis. The principal disorder and the child's level of functioning are the reasons for treatment and the focus of the clinical interventions provided. The need for treatment is determined by a mental health assessment. Treatment is provided by a QMHP or QMHA.

(68) "Treatment plan" means the written documentation of the child's individualized treatment goal(s), measurable objectives and treatment services to be provided. The treatment plan is developed jointly by the QMHP and the child with his or her parent(s) or

guardian, if appropriate. The treatment plan also includes the frequency and duration of the services and the QMHP who is coordinating the services.

(69) "Urgent" means the onset of psychiatric symptoms requiring attention within 72 hours to prevent a serious deterioration in a child's mental condition.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-0970
General Provisions of the System of Care for Children's Community Mental Health Services

The Local Mental Health Authority or designee shall have in place a system of care for children's community mental health services. The Local Mental Health Authority or designee shall:

(1) Establish and maintain comprehensive mental health services for children as defined in ORS 430.630(3);

(2) Assure that mental health services are provided under clinical supervision;

(3) Hold a valid Certificate of Approval issued by the MHDDSD to provide Community Mental Health Treatment Services for Children;

(4) Demonstrate fiscally responsible practices;

(5) Manage the costs of mental health services as required by the MHDDSD;

(6) Assure each subcontractor is in compliance with standards and procedures prescribed in these rules;

(7) Monitor quality assurance and utilization review findings;

(8) Inform the MHDDSD by telephone and in writing within one working day of any critical incident affecting a child and propose the course of action to be taken by the CMHP to investigate or otherwise resolve the incident;

(9) Report suspected child abuse per ORS 419B.010;

(10) Assist children in obtaining and retaining benefits to which they are entitled, including Medicaid and Supplemental Security Income (SSI);

(11) Enroll children in the Client Process Monitoring System when the child's mental health services are funded all or in part by MHDDSD funds, unless the specific service the child receives is provided by an FCHP or MHO whose contract with the MHDDSD does not require enrollment;

(12) Operate programs that value diversity, cultural competence, and have the capacity for cultural self-assessment;

(13) Encourage family involvement in the child's treatment and advocacy on the child's behalf; and

(14) Provide community treatment services for children in a smoke free environment.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-0980
Community Treatment Services

Community treatment services are rehabilitative in nature and may be provided to children outside the clinic setting. Treatment services must be based on sound clinical theory and recognized and widely accepted as clinically appropriate methods of treatment by qualified professionals in the mental health field. At a minimum, the LMHA or designee shall make the following services available in accordance with ORS 430.630:

(1) Community Crisis Services. At a minimum, children's community crisis services shall consist of:

(a) 24 hour, seven days per week face-to-face or telephone screening to determine the need for immediate services for any child requesting assistance or for whom assistance is requested;

(b) 24 hour, seven days per week capability to conduct, by or under the supervision of a QMHP, a mental health status examination to determine the child's condition and the interventions necessary to stabilize the child;

(c) A mental health assessment concluding with written recommendations by the QMHP regarding the need for further treatment;

(d) Provision of appropriate child and family, psychological, and psychiatric services necessary to stabilize the child as quickly as possible;

(e) Referral to the appropriate level of care and linkage to other medical interventions necessary to protect and stabilize the child as quickly as possible; and

(f) Linkage to appropriate social services.

(2) Mental health assessment.

(3) Individual, family and group therapies.

(4) Individual and group psychosocial skill development.

(5) Consultation with professionals involved with the child's treatment.

(6) Psychiatric services as needed for each child.

(7) Medication management and monitoring.

(8) Service planning and coordination.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-0990
Children's Community Treatment Services Admission Criteria

Admission to community treatment services shall be prioritized as follows:

(1) For mental health crisis services:

(a) Any child whose level of functioning indicates an emergency psychiatric condition;

(b) Any child whose level of functioning indicates an urgent psychiatric condition.

(2) For community based mental health treatment services:

(a) Children who, in accordance with the assessment of professionals in the mental health field:

(A) Are at immediate risk of psychiatric hospitalization or removal from home due to a mental or emotional disorder;

(B) Exhibit behavior which indicates high risk of developing disorders of a severe or persistent nature; or

(C) Have a severe mental or emotional disorder.

(b) Any other child who is experiencing mental or emotional disorders which significantly affect the child's ability to function in everyday life, but not requiring hospitalization or removal from home in the near future.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1000
Levels of Care Criteria

Children shall be served in the least restrictive, least intensive setting appropriate to their treatment history, degree of impairment, current symptoms and the extent of family and other supports. The QMHP must recommend the appropriate level of care to the child and parent or guardian when a more restrictive or less restrictive level of care is determined to be medically necessary. The following criteria are to be used to determine the appropriate level of care:

(1) Community based outpatient services. These services may be provided in clinic, home, school, or other settings familiar to and comfortable for the child.

(a) Admission.

(A) Child has a principal diagnosis on Axis I of a completed five-Axes DSM diagnosis; and

(B) Child does not immediately require more restrictive or intensive services.

(b) Continued Stay. At least one of the following is met:

(A) Child is making observed progress toward identified treatment goals as documented in the treatment plan, but treatment goals have not been reached.

(B) Child made no documented progress toward treatment goals, but the treatment plan has been modified based on a clarification of the nature of the identified problems and a re-evaluation of the child's treatment needs.

(C) Child exhibits new symptoms which can be safely and effectively treated at an outpatient level of care. The treatment plan has been revised accordingly.

(c) Discharge.

(A) Child's targeted symptoms have abated as documented by the attainment of goals in the treatment plan; or

(B) Child exhibits new symptoms which may not be safely or effectively treated at an outpatient level of care; and

(C) Child meets admission criteria for a more intensive or restrictive level of care; or

(D) Child is not benefitting from treatment and made no progress toward treatment goals in the last three months, even though appropriate treatment plan reviews and revisions were conducted.

(2) Community based treatment in residential settings. These services may be provided in settings such as Oregon Youth Authority or State Office for Services to Children and Families (SCF) contracted proctor care, therapeutic group homes, treatment foster care and residential facilities co-managed by MHDDSD.

(a) Admission.

(A) Child has a principal diagnosis on Axis I of a completed 5-Axes DSM diagnosis; and

(B) Child's condition is not manageable in the child's current living situation; or

(C) Child cannot reside at home due to the family's level of functioning; and

(D) Child needs treatment provided in a structured, supervised setting; and

(E) Less restrictive or less intensive services are not adequate to meet the child's treatment needs based on:

(i) Documented lack of response to prior treatment; or

(ii) The clinical judgment of the Medicaid Authorization Specialist (MAS) or the CMHP-designated QMHP and the treatment team working with the child.

(b) Continued Stay. At least one of the following is met:

(A) Child is making observed progress toward identified treatment goals as documented in the treatment plan, but treatment goals have not been reached.

(B) Child made no documented progress toward treatment goals, but the treatment plan has been reviewed and modified in order to reevaluate the child's treatment needs, clarify the nature of the identified problems, and/or to initiate new therapeutic interventions; or

(C) Child exhibits new symptoms or maladaptive behaviors that justify continuation and can be safely and effectively treated at an outpatient level of care. The treatment plan has been revised accordingly; and

(D) Child's continued stay has been reviewed and approved by the MAS or designated QMHP every three months.

(c) Discharge.

(A) Child's targeted symptoms and maladaptive behaviors have abated to the baseline level as documented by the attainment of goals in the treatment plan; or

(B) Child exhibits new symptoms and maladaptive behaviors which may not be treated safely or effectively at a community based residential level of care; or

(C) Child is not benefitting from treatment and made no progress toward treatment goals in the last six months even though appropriate treatment plan reviews and revisions were conducted.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1010
Medical Involvement

(1) A comprehensive mental health assessment shall be provided for:

(a) Children with a severe and persistent mental disorder for whom Service Coordination Plans have been developed and who receive Clinical Services Coordination; and

(b) Children who remain in service for at least one year.

(2) The comprehensive mental health assessment shall be maintained in the child's clinical record and shall be updated annually.

(3) A Licensed Medical Practitioner who is either a nurse practitioner or a physician will review and approve each comprehensive mental health assessment and treatment plan required by OAR 309-032-1010(1). The Licensed Medical Practitioner's approval indicates the Medical Necessity of the services.

(4) Children with a severe and persistent mental disorder for whom Service Coordination Plans have been developed and who receive Clinical Services Coordination shall have additional consultation with a Licensed Medical Practitioner who is either a nurse practitioner or a physician within six months of the comprehensive mental health assessment. The consultation documentation shall indicate the Medical Necessity of the continuing services and include one of the following:

(a) A written summary of a consultation between a Licensed Medical Practitioner who is either a nurse practitioner or a physician and the QMHP covering the following criteria:

(A) Symptoms or behaviors persist at a level of severity documented upon admission and the projected time frame for attainment of treatment goals has not been reached as documented in the treatment plan; or

(B) The child's and/or family's progress toward identified treatment goals for this level of care has been documented but not all treatment goals have been reached; or

(C) No progress toward treatment goals has been documented and the treatment plan has been modified to introduce further evaluation in order to clarify the nature of the identified problems and/or new therapeutic interventions have been initiated; or

(D) New symptoms or maladaptive behaviors have appeared while the child is in treatment. Treatment of these symptoms and behaviors has been incorporated into a revised treatment plan. The new symptoms and/or maladaptive behaviors justify continuation of treatment and may be treated safely and effectively with this level of care; or

(b) A written summary of a face-to-face psychiatric or clinical mental health assessment performed by a Licensed Medical Practitioner who is either a nurse practitioner or a physician.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1020
Service Coordination Plan

A Service Coordination Plan shall be developed by the provider for any child with a severe and persistent mental disorder who receives Clinical Services Coordination. The Service Coordination Plan shall include:

(1) A listing of any other providers of the child's mental health services along with the amount, duration, and scope of each provider's services; and

(2) A brief description of the child's service planning in the following domains: legal, education, family, physical health, and social.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1030
Children's Rights

Children and their families receiving mental health care under these rules are entitled to all rights in applicable Oregon Revised Statutes and Oregon Administrative Rules. The rights listed below shall be visibly posted and shall be explained, both verbally and in writing, by the provider to the person legally giving consent to treatment of the child at the time of enrollment.

(1) Consent to treatment. A custodial parent or legal guardian, or a minor child under conditions described below, must give written informed consent to diagnosis and treatment.

(a) Minor children can give informed consent in the following circumstances:

(A) Under age 18 and lawfully married.

(B) Age 16 or older and legally emancipated by the court.

(C) Age 14 or older for outpatient diagnosis and treatment for a mental or emotional disorder. For purposes of informed consent, outpatient treatment does not include treatment provided in residential facilities or in day or partial hospitalization programs.

(b) If the child is initially served in a crisis situation, these rights shall be explained as soon as clinically practical, but not more than five working days from the initiation of services if the child who received the crisis service remains in service.

(2) The custodial parent or legal guardian of any minor, age 14 or older who has consented to outpatient treatment or diagnosis, shall be involved before the end of treatment unless:

(a) The parents refuse;

(b) There are clear clinical indications to the contrary;

(c) The child has been sexually abused by the parent; or

(d) The child has been legally emancipated by the court or has been self sustaining for 90 days prior to obtaining treatment. As

required in ORS 109.675, such refusal or the reasons for exclusion must be documented in the child's clinical record.

(3) Services refusal. The person giving consent to treatment has the right to refuse service, including any specific treatment procedure. If serious consequences may result from refusing a service, the consequences must be explained verbally and in writing by the provider to the custodial parent, guardian or child who is refusing service. Service refusal shall be documented in the clinical record.

(4) Grievances. The child or the person consenting to the child's treatment has the right to lodge an oral or written complaint or file a grievance with the entity providing treatment services. All service providers will:

(a) Have written procedures for accepting, processing and responding to oral or written complaints and grievances. The procedures must include:

(A) The process for registering an oral or written complaint or grievance;

(B) The time lines for processing an oral or written complaint or grievance; and

(C) Notification of the appeals process, including time lines for an oral or written complaint or grievance and the provision of the appropriate appeal forms.

(b) Designate a staff person to receive complaint or grievance information and enter the information into a log. The log will identify, at a minimum, the person lodging the complaint or grievance, the date of the complaint or grievance, the nature of the complaint or grievance, the resolution and the date of the resolution.

(c) Have written procedures for informing children and their legal guardian(s) orally and in writing about the provider's complaint or grievance procedures.

(d) Have written procedures for processing an expedited complaint request if it is believed that the child's health is at risk. A request for expedited complaint must be filed by the child or the person consenting to the child's treatment and must include the following:

(A) A statement that this is a request for an expedited complaint;

(B) An explanation of the urgency of resolving the issue; and

(C) A description of the consequences of following the regular complaint process.

(5) Service denial. The child or the person consenting to treatment on behalf of the child, has the right to appeal when a service has been denied. All providers must have written procedures as described in OAR 309-032-1030(4) for accepting, processing and responding to service denial complaints. In addition to the procedures described in OAR 309-032-1030(4), providers must respond in writing to the complaint within five working days of the complaint. The written response must include:

(a) The service requested;

(b) A statement of service denial;

(c) The basis for the denial; and

(d) Notification of the appeals process including the required time frame to file an appeal and provision of the appropriate appeal forms.

(6) Hearing request. All providers must include in their written appeals process the right of the Medicaid-eligible child, or the person consenting to treatment for the child, to file a request for hearing as a result of a denial of service or an adverse finding against a complainant in accordance with OAR 309-016-0140 through 309-016-0210.

(7) Access to clinical records. The person consenting to treatment, usually the custodial parent or guardian, has the right of access to the child's clinical record. A copy of the record is to be provided within five working days of requesting it. The person requesting the record is responsible for payment for the cost of duplication.

(8) Informed participation in treatment planning. The child, if appropriate, and the custodial parent or legal guardian and others of their choosing, shall have the opportunity to participate in an informed way in the treatment planning process for the child, and in the review, at least every three months, of the child's progress toward treatment goals and objectives. At a minimum, the following information should be discussed:

(a) Treatment and other interventions to be undertaken;

(b) Alternative treatments or interventions available, if any;

(c) Projected time to complete the treatment process;

(d) Benefits which can reasonably be expected; and

(e) Risks that may be involved in treatment, if any.

(9) Confidentiality. No records or information regarding the child which are made confidential by ORS 179.505, 45 CFR 205.50, 42 CFR Part 2 or any other applicable confidentiality law shall be disclosed except as permitted by the applicable law.

(10) Informed consent to fees for services. The amount and payment schedule of any fees to be charged must be disclosed in writing and agreed to by the person consenting to treatment.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1040
Establishment and Maintenance of Clinical Records

(1) Individuality and maintenance of clinical records. A separate, individualized clinical record shall be opened and maintained for each child served by a provider.

(2) Organization of clinical records. Each clinical record shall be uniform in organization, readily identifiable and accessible, and contain all of the components required by these rules in a current and complete manner.

(3) Signature of authors. All documentation required in this rule must be signed by the staff providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed.

(4) Documentation of informed consent. All procedures in these rules requiring consent and the provision of such information to the consenting custodial parent or guardian or where appropriate, the child, shall be documented in the clinical record on forms describing what the child or adult giving consent has been informed of, and asked to consent to, and signed and dated by the consenting person. If the provider does not obtain the required documentation, the reasons must be specified in the clinical record and signed by the qualified supervisor of the person responsible for provision of treatment services to the child.

(5) Error corrections. Errors in the clinical record shall be corrected by lining out the incorrect data with a single line in ink, and then adding the correct information, the date corrected, and the initials of the person making the correction. Errors may not be corrected by removal or obliteration.

(6) Confidentiality of other clients. References to other persons being treated by the CMHP, CMHP subcontractors, FCHP or MHO when included in the child's clinical record shall preserve the confidentiality of the other clients.

(7) Security. Clinical records shall be secured, safeguarded, stored, and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(8) Confidentiality of records. All clinical records are confidential to the extent provided for in 309-032-1030(9).

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1050
Clinical Record Documentation Requirements

The child's clinical record shall contain adequate written information which is readily accessible and uniformly placed in the clinical record to document the diagnosed mental disorder and the child's need for treatment for the diagnosis. The documentation shall include:

(1) CPMS enrollment data if required by OAR 309-032-0960(30);

(2) Identifying data including child's name, date of birth, sex, address, phone number, and name of parent(s) or legal guardian including an address and phone number if different.

(3) A mental health assessment;

(4) An individualized treatment plan;

(5) Written discharge criteria;

(6) A comprehensive mental health assessment as required in OAR 309-032-1010.

(7) A Service Coordination Plan as required by OAR 309-032-1020.

(8) Written progress notes for each service provided;

(9) A written discharge summary; and

(10) A medication service record if medication is prescribed on the treatment plan.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1060
Quality Assurance Requirements

Providers will have a planned, systematic and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of services provided to children and families. Providers will implement a Quality Assurance system which will assure compliance with the provisions of OAR 309-032-0950 through 309-032-1080. The Quality Assurance system shall include a Quality Assurance Committee and a Quality Assurance Plan which together implement a continuous cycle of measurement, assessment and improvement of clinical outcomes based on input from service providers and representatives of the children and families served.

(1) The Quality Assurance Committee shall carry out the Quality Assurance Plan and shall be the catalyst for improvement in the organization's clinical outcomes. The Quality Assurance Committee shall be composed of:

(a) One or more QMHPs, including an LMP who is preferably a child psychiatrist, who are representative of the scope of services delivered;

(b) A representative or representatives of the children and families served;

(c) Other persons who have the ability to identify, design, measure, assess and implement clinical and organizational changes.

(2) The Quality Assurance Committee duties shall:

(a) Identify indicators of quality;

(b) Identify measurable and time-specific performance objectives;

(c) Identify data sources to measure performance;

(d) Develop a process to systematically collect outcome data and identify staff who will collect and analyze data;

(e) Oversee the data collection process;

(f) Analyze the information collected and measure progress toward performance objectives;

(g) Identify clinical and operational changes necessary to achieve performance objectives;

(h) Implement clinical or operational changes that are indicated by the achievement or non-achievement of performance objectives; and

(i) Reassess and, if necessary, revise objectives and methods to measure performance on an ongoing basis.

(3) The Quality Assurance Committee shall meet at least quarterly.

(4) The written Quality Assurance Plan shall describe the implementation and ongoing operation of the functions performed by the Quality Assurance Committee. The Quality Assurance Plan shall include:

(a) A description of the Quality Assurance Committee's authority to identify and implement clinical and organizational changes;

(b) The composition and tenure of the Quality Assurance Committee;

(c) The schedule of Quality Assurance Committee meetings;

(d) The policies and procedures for identifying and using objective and measurable performance objectives.

(e) The policy and procedures for identifying and using data sources;

(f) The indicators of quality in the following domains:

(A) Access to services;

(B) Quality of care;

(C) Integration and coordination; and

(D) Outreach and prevention.

(g) The policies and procedures for reporting, tracking, investigating, and analyzing reports of critical incidents;

(h) The policies and procedures for both reviewing documentation and determining that the staff have the required competencies and credentials to perform assigned duties and meet the provider's performance objectives;

(i) The policies and procedures to manage utilization of services;

(j) The policies and procedures for reviewing complaint and grievance information; and

(k) The policies and procedures for clinical record reviews.

(5) A written summary of the pertinent facts and conclusions of each Quality Assurance Committee meeting will be maintained and be available for review by the MHDDSD, CMHP, MHO or FCHP.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1070
Certificate of Approval to Provide Community Based Mental Health Treatment Services

Providers of community mental health outpatient children's mental health services and providers operating under ORS 743.556 must be in compliance with OAR 309-032-0950 through 309-032-1080 and must hold a valid Certificate of Approval to provide Community Mental Health Treatment Services for Children from the MHD DSD as described in OAR 309-012-0130 through 309-012-0220. The Certificates will be issued as follows:

(1) A provider who is determined by the MHDDSD to be in substantial compliance with applicable rules will receive a three year Certificate of Approval.

(2) A provider who is determined by the MHDDSD to not be in substantial compliance with applicable rules may, at the discretion of the MHD DSD, have conditions placed on the Certificate of Approval.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

309-032-1080
Sanctions for Non-Compliance

(1) Programs or services not in substantial compliance. When the MHDDSD determines, pursuant to this rule that a provider is not in substantial compliance with these rules, the MHDDSD may, at its discretion, require the provider to file a Plan of Correction within a period of time specified by the MHDDSD.

(2) MHDDSD authority. The MHDDSD may accept, reject, or modify the Plan of Correction or require the provider to comply with a Plan of Correction as directed and approved by the MHDDSD.

(3) Sanctions. Sanctions may include, at the discretion of the MHDDSD, elimination of the service or program, termination of the Certificate of Approval to provide Community Mental Health Treatment Services for Children, merger with an approved CMHP, or if applicable, withholding of funds.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist: MHD 6-1996, f. & cert. ef. 10-1-96

Standards for Children's Intensive Mental Health Treatment Services

309-032-1100
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for intensive mental health treatment services for children within a comprehensive system of care. The goal of these services is to maintain the child in the community in the least restrictive treatment setting appropriate to the acuity of the child's disorder. The system of care shall be child and family-centered and community-based with the needs of the child and family determining the types and mix of services provided. These services may be as intensive, frequent and individualized as is medically appropriate to sustain the child in treatment in the community.

(2) Statutory Authority. These rules are authorized by ORS 430.041, 430.640(1)(h), and 743.556 to carry out the provisions of ORS 430.630.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1110
Definitions

As used in these rules:

(1) "Accreditation" means official notification given a provider of compliance to standards established by an accrediting organization approved by the Health Care Financing Administration to accredit providers of Medicaid reimbursed "inpatient under 21."

(2) "Active treatment" means implementation of a professionally developed and supervised individual plan of care to improve a child's condition.

(3) "Acute care" means short term psychiatric treatment in a hospital or other equivalent level of care.

(4) "Admission criteria" means the behavioral and diagnostic requirements to be met for a child to be admitted to intensive mental health treatment services.

(5) "Assessment and Evaluation Program" means a service designed for children who need non-hospital level psychiatric assessment, evaluation and brief treatment in a staff or facility secure program.

(6) "Behavior management policy" means the written policies and procedures adopted by the provider that describe the behavioral interventions to be used by the provider to manage maladaptive or problem behavior of an admitted child.

(7) "Case management" means the service provided to children and families to link and coordinate segments of the service delivery system of a single provider or of several providers to ensure that the most effective means of meeting the child's needs for care are used. Case management functions for children with intensive treatment needs include planning specific treatment goals and services needed to achieve goals; linking the child to appropriate services delineated in the care plan; monitoring and ongoing contact with the child to ensure that services are being delivered appropriately; and advocating for the child's clinical needs.

(8) "Certification" means official approval given by the Division to an appropriately licensed and/or accredited provider to deliver intensive treatment services.

(9) "Chemical restraint" means the administration of medication for the acute management of uncontrolled behavior. Chemical restraint is different from the use of medication for treatment of symptoms of severe emotional disturbances and/or disorders. Chemical restraint of children is prohibited.

(10) "Child" or "Children" means a person or persons under the age of 18, or for those with Medicaid eligibility under the age of 21, who receives ITS services.

(11) "CHIP" means the Child Health Insurance Program federal grant-in-aid program to states under Title XXI of the Social Security Act.

(12) "Client Process Monitoring System" or "CPMS" means the Division's client information system for community based services.

(13) "Clinical record" means the collection of all documentation regarding a child's mental health treatment. The record is a legal document. The clinical record provides the foundation for managing and tracking the provision and quality of services.

(14) "Clinical supervision" means the documented oversight by a Clinical Supervisor of mental health treatment services provided by Qualified Mental Health Professionals or Qualified Mental Health Associates.

(15) "Clinical supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting. The clinical supervisor, as documented by the provider, operates within the scope of his or her practice or licensure, and demonstrates the competency to oversee and evaluate the mental health treatment services provided by other Qualified Mental Health Professionals or Qualified Mental Health Associates.

(16) "Comprehensive mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and mental status; and emotional, cognitive, family, substance use, behavioral, social, physical, nutritional, school or vocational, recreational and cultural functioning; and developmental, medical and legal history. A comprehensive mental health assessment is collected through interview with the child, family and other relevant persons; review of previous treatment records; observation; and psychological and neuropsychological testing when indicated. The comprehensive mental health assessment concludes with a completed DSM five axis diagnosis, clinical formulation, prognosis for treatment, and treatment recommendations. The comprehensive mental health assessment is used to document the need for mental health services and to develop or update the child's individual plan of care.

(17) "Consent to treatment" means the informed, voluntary, written agreement as required in ORS 430.210(d) between the provider and the child's custodial parent or guardian, or the child if legally emancipated, for the child to receive prescribed treatment for a specific diagnosis.

(18) "Consultation" means professional advice or explanation given concerning a specific child to others involved in the treatment process, including family members, staff members of other human service agencies and care providers.

(19) "Contractor" means a CMHP, MHO or other entity approved by the Division for contracting or subcontracting to purchase intensive mental health treatment services for children. A contractor is responsible for assuring that the provider of contracted services meets the requirements established in this rule including applicable licensing, certification and accreditation standards and holds a valid Certificate of Approval issued by the Division.

(20) "Continued stay criteria" means the diagnostic, behavioral and functional indicators documented in the child's plan of care by the interdisciplinary team to provide the clinical rationale for a child to remain in an intensive mental health treatment service.

(21) "Crisis" means either an urgent or emergency situation that occurs when a child's mental status, emotional stability, or functioning evidences a rapid deterioration and there is an immediate need to address the situation to prevent further deterioration in the child's condition.

(22) "Custodial parent" means the parent(s) or guardians having legal custody of the child.

(23) "Custody" means the legal care and supervision of the child by the person, agency or institution having the authority to authorize ordinary, urgent or emergent medical, psychiatric, psychological and other remedial care and treatment for the child. The custodial parent(s) is not required to relinquish custody of the child to receive mental health treatment services.

(24) "Diagnosis" means the primary mental disorder listed in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), that is the medically appropriate reason for clinical care and the main focus of treatment. The primary diagnosis is determined through the mental health assessment and any examinations, tests, procedures or consultations suggested by the assessment. A DSM "V" code condition, substance use disorder or mental retardation is not considered the primary diagnosis covered under these rules although these conditions or disorders may co-occur with the diagnosable mental disorder.

(25) "Direct supervision" means the oversight and coordination by a QMHP of interventions described in the individual plan of care performed by a Qualified Mental Health Associate (QMHA) and other direct care staff. Direct supervision also includes reviewing and evaluating the documentation of interventions directed by the individual plan of care performed by a QMHA or other direct care staff. Direct supervision is performed on a regular, routine basis in an individual or group setting.

(26) "Direction of the psychiatrist" means medical oversight of the clinical aspects of care required of accredited "inpatient under 21" providers by the Health Care Financing Administration (HCFA). Medical oversight includes participation on the interdisciplinary team, prescribing treatment on individual plans of care by signature, prescribing and/or monitoring medications and reviewing special treatment procedures.

(27) "Discharge criteria" means the diagnostic, behavioral and functional indicators the child and/or family will meet to move to the next level of service.

(28) "Discharge instructions" means a brief document which transmits information about the child's ongoing care and treatment needs. Discharge instructions include current medication and medical information, diagnosis and current treatment intervention strategies to manage the child prior to receiving a discharge summary. Discharge instructions shall be part of the information given to the parent or guardian upon or prior to discharge.

(29) "Discharge summary" means written documentation of the last service contact with the child; the diagnosis at admission; and a summary statement that describes the effectiveness of treatment modalities and progress, or lack of progress, toward treatment objectives while in service. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning and prognosis and recommendations for further treatment.

(30) "Division" means the Department of Human Services Agency responsible for the administration of mental health and developmental disabilities programs and laws of the state.

(31) "DSM" means the current edition of the "Diagnostic and Statistical Manual of Mental Disorders" published by the American Psychiatric Association.

(32) "Enrollment" means the assignment of Oregon Health Plan clients to Mental Health Organizations (MHOs), Oregon Health Plan Managed Care Enrollment Requirements.

(33) "Family" means the parent(s), legal guardian, siblings, grandparents, spouse and other primary relations of the child whether by blood, adoption, legal or social relationship.

(34) "Five-axis diagnosis" means the multiaxial system of evaluation in the DSM organized to provide a comprehensive approach to psychiatric assessment and to ascertain that all of the information necessary for planning treatment and predicting treatment outcomes for children is recorded on each of five axis.

(35) "Formal complaint" means the expression in a manner appropriate to the child or family/guardian of dissatisfaction or concern about the provision or denial of services that is the responsibility of the provider under these rules. The formal complaint can be expressed by a child or by the child's representative.

(36) "Fully Capitated Health Plan" or "FCHP" means a prepaid health plan under contract with the Office of Medical Assistance Programs to provide capitated physical health and chemical dependency services under the Oregon Health Plan. Some FCHPs also serve as Mental Health Organizations.

(37) "Goal" means an expected result or condition to be achieved, which is specified in a statement of relatively broad scope, provides a guideline for the direction of care and is related to an identified clinical problem.

(38) "Guardian" means a parent, other person or agency legally in charge of the affairs of a minor child and having the authority to make decisions of substantial legal significance concerning the child.

(39) "Indicators of progress" means the diagnostic, behavioral, or functional measures used by the provider to demonstrate the degree to which a child and family have made functional or behavioral improvement in the areas being measured.

(40) "Individual plan of care" means the written plan developed by a QMHP for active treatment for each child admitted to an intensive treatment service program. The individual plan of care specifies the DSM diagnosis, goals, measurable objectives, and specific treatment modalities and is based on a completed mental health assessment or comprehensive mental health assessment of the child's functioning and the acuity and severity of psychiatric symptoms.

(41) "Individuals with Disabilities Education Act" or "IDEA" means the federal law requiring that a free and appropriate education be provided to all children with mental and physical handicapping conditions. The education provided must include all educational and related services necessary for the child to learn.

(42) "Initial plan of care" means the written plan developed by a QMHP for active treatment based on the mental health assessment completed at admission. The initial plan of care specifies assessment and treatment modalities before completing the individual plan of care.

(43) "Intensive treatment services" or "ITS" means the range of service components in the system of care inclusive of treatment foster care, therapeutic group homes, psychiatric day treatment, partial hospitalization, residential psychiatric treatment, sub-acute care or other services as determined by the Division that provides active psychiatric treatment for children with severe emotional disorders and their families.

(44) "Interdisciplinary team" means a team of qualified treatment and education professionals including a child and adolescent psychiatrist or LMP and the child's parent or guardian responsible for assessment and evaluation, the development and oversight of individual plans of care, and the provision of treatment for children admitted to an intensive treatment services program.

(45) "Isolation" means the staff-directed placement of a child in a room or other space in which the child is alone and without ongoing verbal or visual contact with others. Periodic visual or verbal contact by staff does not prevent the child from being considered to be in isolation. A child who is placed in his or her bedroom at the child's normal bedtime or otherwise has a routine separation unrelated to behavior or conduct is not considered to be isolation.

(46) "Level of care" means the relative amount and intensity of mental health services provided from the least restrictive and least intensive in a community-based setting to the most restrictive and most intensive in an inpatient setting. As required in ORS 430.210(a), children are to be served in the most normative, least restrictive, least intrusive level of care appropriate to their treatment history, degree of impairment, current symptoms and the extent of family or other supports.

(47) "Level of functioning" means the description and numeric quantification on Axis V of a DSM diagnosis of the effectiveness of a child's ability to achieve or maintain developmentally appropriate behavior in one or more of the following areas: role and task performance, cognition and communication, behavior toward self and others, and mood and emotions as measured against age appropriate norms.

(48) "Licensed Medical Practitioner" or "LMP" means any person who meets the following minimum qualifications as documented by the provider:

(a) Holds at least one of the following educational degrees and valid licensure:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon;

(C) Physician's Assistant licensed to practice in the State of Oregon; and

(b) A Licensed Medical Practitioner contracting or employed for the first time with a provider under these rules after July 1, 2000, shall be a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(49) "Manual restraint" means the act of involuntarily restricting a child's movement by holding the whole or a portion of a child's body in order to protect the child or others from injury. The momentary periods of physical restriction by direct contact with the child, without the aid of material or mechanical devices, accomplished with limited force, that prevent the child from completing an act that would result in potential physical harm to the child or others are not considered to be restraint.

(50) "Mechanical restraint" means the use of any physical device to involuntarily restrain the movement of all or a portion of a child's body as a means of controlling his or her physical activities in order to protect the child or other persons from injury. Mechanical restraint shall only be used by Sub-Acute providers specifically authorized in writing to use mechanical restraint by the Division. Mechanical restraint does not apply to movement restrictions stemming from physical medicine, dental, diagnostic or surgical procedures which are based on widely accepted, clinically appropriate methods of treatment by qualified professionals operating within the scope of their licensure.

(51) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to poor and indigent persons under Title XIX of the Social Security Act.

(52) "Medically appropriate" means services which are required for prevention (including preventing a relapse), diagnosis or treatment of mental health conditions and which are appropriate and consistent with the diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental condition; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the provider of the services, child or family; and the most cost effective of the alternative levels of medically appropriate services which can be safely and effectively provided to the child and family in the LMP's judgement.

(53) "Medication service record" means the documentation of written or verbal orders for medication, laboratory and other medical procedures issued by a Licensed Medical Practitioner employed by, or under contract with, the provider and acting within the scope of his or her license. The provision of medication services is documented in written progress notes and/or medication administration records and placed in the client's record.

(54) "Mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and relevant child and family history, mental status examination and DSM 5-axis diagnosis or provisional diagnosis.

(55) "Mental Health Information System" means the information system of the Division that includes the Client Process Monitoring System for non-hospital services, the Medicaid Management Information System for the Medicaid eligible population and billable services delivered, and the Oregon Patient Resident Care System for inpatient and acute services. It provides a statewide client registry for tracking services utilization and contractor capacity.

(56) "Mental Health Organization" or "MHO" means a prepaid health plan under contract with the Division to provide covered services under the Oregon Health Plan.

(57) "Mental status examination" means the face-to-face assessment by a QMHP of a child's mental functioning within a developmental and cultural context that includes descriptions of appearance, behavior, speech, language, mood and affect, suicidal or homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, concentration, general knowledge, intellectual ability, abstraction abilities, judgment, and insight appropriate to the age of the child.

(58) "Milieu" means the daily environment of structure and therapy, education, recreation and socialization interactions with staff and peers for children in treatment.

(59) "Minor child" means an unmarried person under the age of 18.

(60) "Non-custodial parent" means a parent whose custodial responsibilities have been removed by the court by divorce decree. Under ORS 107.154, and unless otherwise ordered by the court, non-custodial parents have the same rights to consult with any person who may provide care and treatment for the child and to inspect and receive the child's medical and psychological records to the same extent as the custodial parent.

(61) "Objective" means a quantifiable statement of a desired future state or condition which is related to the attainment of a goal within a stated deadline for achievement.

(62) "Oregon Youth Authority (OYA)" means the department of state government created by the 1995 Legislative Assembly that is charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.

(63) "Partial hospitalization program" means a comprehensive interdisciplinary day treatment program certified under this rule to provide psychiatric services, therapy, education and therapeutic activities as an alternative to hospitalization which meets Health Care Financing Administration accreditation standards.

(64) "Plan of correction" means a written document which specifies actions that a provider will take to come into compliance with these rules.

(65) "Progress note" means the written documentation of the clinical course of treatment.

(66) "Provider" means an organization or agency certified by the Division to provide intensive mental health treatment services for children.

(67) "Provisional diagnosis" means a statement on Axis I of a DSM diagnosis when there is a strong presumption that the full criteria for the diagnosis will ultimately be met.

(68) "Psychiatric Day Treatment" means the comprehensive, interdisciplinary, non-residential community based program certified under this rule consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.

(69) "Psychiatric Residential Treatment Facility" or "PRTF" means the behavioral health care programs certified under this rule to provide 24-hour, seven days per week active mental health treatment under the direction of a psychiatrist for children under age 21. These services are associated with a Residential Psychiatric Treatment Program for children who can benefit from a less restrictive residential psychiatric environment.

(70) "Psychiatrist" means a Licensed Medical Practitioner who is board-eligible or board-certified in child and adolescent psychiatry and licensed to practice in the State of Oregon.

(71) "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the direct supervision of a Qualified Mental Health Professional and who meets the following minimum qualifications as documented by the provider:

(a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three years work, education, training or experience; and

(b) Has the competency necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts;

(C) Provide psychosocial skills development; and

(D) Implement interventions as assigned on an individual plan of care.

(72) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner or any other person who meets the following minimum qualifications as documented by the provider:

(a) Holds any of the following educational degrees:

(A) Graduate degree in psychology;

(B) Bachelor's degree in nursing and licensed by the State of Oregon;

(C) Graduate degree in social work;

(D) Graduate degree in a behavioral science field;

(E) Graduate degree in recreational, music, or art therapy;

(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(b) Whose education and experience demonstrate the competency to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise an individual plan of care; conduct a Comprehensive Mental Health Assessment and provide individual, family and/or group therapy within the scope of their training.

(73) "Quality Management" means a continuous process to simultaneously promote consistency of performance and to promote meaningful change in measurable objectives. The process is used to improve a provider's performance and adjust measurable objectives and benchmarks.

(74) "Quality of care" means the degree to which services are consistent with best practices and produce desired and satisfactory mental health outcomes for the child.

(75) "Reportable incident" means an event in which an admitted child while in the program is believed to have been abused, endangered or significantly harmed. This may include, but is not limited to, incidents as a result of staff action or inaction, incidents between children, incidents that occur on passes, or incidents of self-harm where medical attention is necessary.

(76) "Residential Psychiatric Treatment Program" means the behavioral health care programs certified under this rule to provide 24-hour, seven days per week active mental health treatment under the direction of a psychiatrist for children under age 21.

(77) "Seclusion" means the involuntary confinement of a child alone in a specifically designed room from which the child is physically prevented from leaving.

(78) "Severe emotional disorder" means an emotional, mental, and/or neurobiological impairment which is manifested by emotional or behavioral symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism and which continue for more than one year, or on the basis of a specific diagnosis is likely to continue for more than one year.

(79) "Special treatment procedures" means seclusion; manual restraint; staff directed isolation for more than five hours in five days or a single episode of two hours; and experimental practices and research projects that involve risk to a child.

(80) "Special Treatment Procedures Committee" means the committee established or designated by the provider to review special treatment procedures.

(81) "State Office for Services to Children and Families (SOSCF) or (SCF)" means the Division serving as Oregon's child welfare agency.

(82) "Sub-Acute Psychiatric Care" means mental health treatment under the clinical direction of a psychiatrist as an alternative to hospitalization certified under this rule for children who are not in the most acute phase of a mental condition but who require a level of care higher than that provided in a residential psychiatric treatment setting.

(83) "System of care" means the comprehensive array of mental health and other necessary services which are organized to meet the multiple and changing needs of children with severe emotional disorders and their families.

(84) "Therapeutic group home" means mental health treatment settings certified under this rule for children in group care homes of eight or fewer children in SCF-licensed homes where the home parents are employed or contracted by the supervising agency to provide in-home psychosocial skills development for each child.

(85) "Treatment foster care" means mental health treatment settings certified under this rule for children residing in SCF certified homes where the home parents are employed or contracted by the

supervising agency to provide in-home psychosocial skills development for each child.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1120
General Conditions of Participation for Children's Intensive Mental Health Treatment Services Providers

Providers delivering children's intensive mental health services shall:

(1)(a) Hold, and/or assure that subcontractors hold, a valid Certificate of Approval issued by the Division and, if applicable, accreditation approved by the Division and the Health Care Financing Administration and appropriate license or certification from the State Office for Services to Children and Families;

(b) Providers that are not required to have accreditation approved by the Health Care Financing Administration may use alternative standards for the organization of their services;

(A) Alternative standards include the Day and Residential Treatment Services (DARTS) Standards or others approved by the Division;

(B) In the event of a conflict between this rule and voluntary standards, the standards and procedures outlined in this rule will supercede all alternative standards.

(2) Maintain the organizational capacity and interdisciplinary treatment capability to deliver clinically and developmentally appropriate services in the medically appropriate amount, intensity and duration for each admitted child specific to the child's diagnosis, level of functioning and the acuity and severity of the child's psychiatric symptoms;

(3) Maintain 24 hour, seven days per week treatment responsibility for admitted children. Non-residential programs shall maintain on-call capability at all times to respond directly or by referral to the treatment needs of admitted children including crises 24 hours per day, seven days per week;

(4) Deliver active psychiatric treatment in the least restrictive, least intensive setting appropriate to each admitted child's treatment history, diagnosis, development, level of functioning and degree of impairment, current symptoms and the extent of family and other supports;

(5) Use treatment methods appropriate for children with severe emotional disorders that are based on sound clinical theory and professional standards of care and widely accepted by qualified professionals in the mental health field;

(6) Demonstrate family involvement and participation in all phases of assessment, treatment planning and the child's treatment by documentation in the clinical record;

(7) Report suspected child abuse as required in ORS 419B.010;

(8) Maintain reportable incident files including:

(a) Child abuse reports made by the provider to law enforcement or the State Office for Services to Children and Families child protective services documenting the dates of the incident the persons involved and, if known, the outcome of such reports; and

(b) Reportable incident information documenting the date of the incident, the persons involved, the quality and performance actions taken to initiate investigation of the incident, and correct any identified deficiencies.

(9) Inform the Division and the legal guardian within one working day of reportable incidents.

(10) Enroll children in the Mental Health Information System when the child's mental health services are funded all or in part by Division funds, unless the Division contract does not require enrollment;

(11) Maintain policies and practices prohibiting on- or off-site non-professional relationships and activities between employees and admitted children and their families unless the activities are approved by the provider and interdisciplinary team and identified as clinically appropriate services in the child's individual plan of care;

(12) Provide services for children in a smoke free environment in accordance with Public Law 103.277, the Pro-Child Act;

(13) Establish systematic and objective methods to accomplish the following:

(a) Periodically monitor and evaluate access to, and provision of, children's intensive mental health treatment services;

(b) Identify and seek to resolve problems in access to, or provision of, services; and

(c) Improve access and services using reliable and valid performance measures; and to periodically report pertinent data and information as directed by the Division.

(14) Demonstrate education service integration in all phases of assessment, treatment planning, active treatment, and discharge planning by documentation in the clinical record; and

(15) Maintain policies and procedures to ensure the safety and emergency needs of children, families, staff and visitors including:

(a) First aid and cardiopulmonary resuscitation training for staff who are assigned to provide direct service to children;

(b) Off campus activities;

(c) Medical and/or dental emergencies; and

(d) Facility and environmental emergencies.

(16) Demonstrate cultural competency, gender responsiveness and language appropriateness in the delivery of services to clients.

(17) Demonstrate operation by a governing body whose membership reflects diverse community interests and whose organization and operation shall be set out in writing.

(18) Develop and publish a comprehensive document which describes the mission statement, treatment philosophy, programmatic descriptions, admission criteria, and the policies and procedures for operation of the program.

(19) Develop policies and procedures for orientation of the incoming child and family that consider pre-admission orientation times convenient for the family and that facilitate adequate staff program and child and family preparation prior to admission.

(20) Develop policies and procedures prohibiting firearms and outlining the management of other potentially dangerous objects.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1130
General Treatment Requirements

(1) Admission. Providers shall plan admissions, help the child and family understand the reason for admission, give admission consideration to children that realistically allows the child's family to participate in treatment, and advise the family on transportation arrangements when needed.

(2) Prior to admission for planned admissions or within 14 days following an emergency admission, providers shall determine that a child is eligible for intensive treatment services. Admissions shall be based on the provider's clinical review of the child's functioning, of the severity and acuity of the child's psychiatric symptoms, and of documentation of the following:

(a) A completed five-axis diagnosis current within 60 days of the admission date;

(b) Pertinent biological, psychological and sociocultural factors influencing the child's development and functioning;

(c) The acuity and severity of the child's psychiatric symptoms as scored on measures established by the Division;

(d) The child's functioning as scored on measures established by the Division; and

(e) Attempts to effectively treat the child in a less restrictive level of care.

(3) Assessment.

(a) On admission the child shall have an initial plan of care based on a mental health assessment completed by a QMHP.

(b) A comprehensive mental health assessment shall be conducted by the provider's interdisciplinary team and be completed within 30 treatment days after admission.

(c) The comprehensive assessment shall be revised and updated annually.

(4) Active Treatment and Individual Plans of Care.

(a) Providers shall fully inform the child in developmentally appropriate language and obtain informed consent from the child's parent(s) or guardian about the proposed care and shall document in the child's clinical record that the following information has been reviewed, discussed, and agreed to by the participants:

(A) Active treatment and other interventions to be undertaken;

(B) Alternative treatments or interventions available, if any;

(C) Projected time to complete the treatment process;

(D) Indicators by which progress will be measured;

(E) Benefits which can reasonably be expected;
(F) Risks of treatment, if any;
(G) Prognosis for treatment; and
(H) Discharge plan.
(b) The individual plan of care shall clinically support the level of care to be provided and shall:
(A) Be developed and implemented no later than 14 treatment days after admission by an interdisciplinary team in consultation with the child, the parent(s) or guardian and the provider to which the child will be discharged;
(B) Be based on a mental health assessment of the child's functioning, the acuity and severity of the child's psychiatric symptoms, diagnosis, and the biological, medical, psychological and sociocultural factors that influence the child's development and functioning;
(C) State treatment goals and measurable and observable objectives;
(D) Prescribe an integrated program of therapies, activities, interventions and experiences designed to meet the goals;
(E) Include a discharge plan to ensure continuity of care with the child's family, school, and community upon discharge; and
(F) Be signed and dated by the psychiatrist and other members of the interdisciplinary team including the child's guardian, and when appropriate the child.
(5) Individual Plan of Care Review. A written summary of each individual plan of care review shall be filed in the child's clinical record. Revisions shall be implemented as necessary based on each child's individualized response to the treatment interventions.
(a) The review in nationally accredited sub-acute, assessment and evaluation programs and residential psychiatric treatment programs shall be conducted every 30 days by the interdisciplinary team.
(b) In other programs, the review shall be conducted every 30 days by the child's interdisciplinary team. The psychiatrist shall participate in the review at least every 90 days.
(6) Discharge Planning and Coordination.
(a) Providers shall establish written policies and practices for identifying, planning and coordinating discharge to after-care resources. At a minimum, the provider's interdisciplinary team shall:
(A) Integrate discharge planning into ongoing treatment planning and documentation from the time of admission, and specify the discharge criteria that will indicate resolution of the symptoms and behaviors that justified the admission;
(B) Review and, if needed, modify the discharge plan every 30 days;
(C) Include the parent, guardian and provider to which the child will be discharged in discharge planning and reflect their needs and desires to the extent clinically indicated;
(D) Finalize the discharge plan prior to discharge and identify in the plan the continuum of services and the type and frequency of follow-up contacts recommended by the provider to assist in the child's successful transition to the next appropriate level of care; and
(E) Assure that appropriate medical care and medication management will be provided to clients who leave through a planned discharge. The discharging provider's interdisciplinary team shall identify the medical personnel who will provide continuing care and shall also arrange an initial appointment with that provider.
(b) Providers shall give written discharge instructions to the child's parent(s) or guardian, or the provider of the next level of care on the date of discharge.
(c) Providers shall notify the child's parent(s) or guardian and the provider to which the child will be discharged of the anticipated discharge dates at the time of admission and when the discharge plan is changed.
(d) Providers shall not discharge a child from an intensive treatment service unless the interdisciplinary team, in consultation with the child's parent(s) or guardian or the provider of the next level of care, determines that the child requires a more or less, restrictive level of care. If the determination is to admit the child to acute care, the provider shall not discharge the child from the program during the acute care stay unless the interdisciplinary team, in consultation with the child's parent(s) or guardian or the provider of the next level of care determines that the child requires a more or less restrictive level of care.
(e) A discharge summary reflecting the active course of treatment shall be completed and placed in the chart within 15 treatment days following discharge.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1140
General Staffing and Personnel Requirements

(1) Providers of children's intensive mental health treatment services shall have the clinical leadership and sufficient QMHP, QMHA and other staff to meet the 24-hour, seven days per week treatment needs of admitted children and shall establish policies, contracts and practices to assure:
(a) Availability of psychiatric services to meet the following requirements:
(A) Provide medical oversight of the clinical aspects of care in nationally accredited sub-acute, assessment and evaluation programs and residential psychiatric treatment programs and provide 24-hour, seven days per week psychiatric on-call coverage; or consult on clinical care and treatment in psychiatric day treatment, partial hospitalization, therapeutic group homes and treatment foster care programs;
(B) Assess each child's medication and treatment needs, prescribe medicine or otherwise assure that case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the child's individual plan of care goals; and
(C) Participate in the provider's interdisciplinary team and Quality Management process.
(b) An executive director or clinical director who meets the following minimum qualifications:
(A) Masters degree in a human service-related field from an accredited school;
(B) Five years experience in a human services program;
(C) Documented professional references, training and academics; and
(D) Subscribes to a professional code of ethics.
(2) Providers of children's intensive mental health services shall have adequate numbers of QMHP, QMHA and other staff whose care specialization is consistent with the duties and requirements of the specific level of care. Professional staff shall operate within the scope of their training and licensure.
(3) Providers shall assure through documentation in personnel files that all supervisory and clinical staff meet all applicable professional licensing and/or certification, and QMHP or QMHA competencies.
(4) Providers shall maintain a personnel file for each employee, that contains:
(a) The employment application;
(b) Verification of a criminal history check as required by ORS 181.536–181.537;
(c) A written job description;
(d) Documentation and copies of relevant licensure and/or certification that the employee meets applicable professional standards;
(e) Annual performance appraisals;
(f) Annual staff development and training activities;
(g) Employee incident reports;
(h) Disciplinary actions;
(i) Commendations; and
(j) Reference checks.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1150
System of Care

(1) General Requirements. All ITS providers described in this section shall meet the following general requirements:
(a) Active psychiatric treatment and education services shall be functionally integrated in a therapeutic milieu designed to promote achievement of goals and treatment objectives developed in each child's individual plan of care.
(b) ITS facilities shall meet all applicable licensing, certification and accreditation/or standards for plant technology, safety manage-

ment, professional staffing, therapeutic environment, performance measurement, quality management and utilization review.

(c) ITS providers shall maintain linkages with primary care physicians, CMHPs and MHOs and the child's parent(s) or guardian to plan for necessary continuing care resources for the child.

(d) ITS providers shall maintain linkages with the applicable education service district or school district to coordinate and provide the necessary educational services for the children.

(e) When treatment services interrupt the child's day to day educational environment, the program provides or makes arrangements for the continuity of the child's education.

(f) ITS providers shall ensure that the following services be available and accessible through direct service, contract or by referral:

(A) Psychiatric and psychological assessment and treatment;

(B) Individual, group and family therapies;

(C) Medication evaluation, management and/or monitoring;

(D) Pre-vocational/vocational rehabilitation;

(E) Therapies supporting speech, language and hearing rehabilitation;

(F) Individual and group psychosocial skills development;

(G) Behavior management;

(H) Activity and recreational therapies;

(I) Nutrition;

(J) Physical health care services or coordination; and

(K) Case management, treatment planning and coordination, and consultation.

(g) Family therapy shall be provided by a Qualified Mental Health Professional. The family therapist to child ratio shall be at least one family therapist for each 12 children.

(h) There shall be a clinical supervisory ratio of at least one QMHP clinical supervisor for each nine staff.

(i) Providers of ITS shall measure individual active treatment outcomes for children in treatment with the provider. Measurement of active treatment outcomes shall include, but are not limited to:

(A) Stabilization of the acuity and severity of symptoms;

(B) Reduction of danger to self or others;

(C) Improvement in the level of function;

(D) Stabilization of behavior and conduct; and

(E) Development of new adaptive coping skills.

(2) In addition to the general requirements for all ITS providers listed in 309-032-1150(1), the following service specific requirements shall be met.

(3) Psychiatric Residential Treatment Services. These services are structured treatment environments with daily 24-hour supervision and active psychiatric treatment. It includes Sub-Acute Psychiatric Care, Assessment and Evaluation Programs, Residential Psychiatric Treatment Programs, and Psychiatric Residential Treatment Facilities. Psychiatric Residential Treatment Services are provided by nationally accredited providers certified under these rules for children who require active treatment for a diagnosed mental disorder in a 24-hour residential setting. An education program provided and admitted children shall have, or have been screened for, an Individual Education Plan, Personal Education Plan, and/or an Individual Family Service Plan.

(a) Providers of Psychiatric Residential Treatment Services shall maintain one or more linkages with acute care hospitals and/or MHOs to coordinate necessary inpatient care.

(b) Psychiatric residential clinical care and treatment shall be under the direction of a medical director who is a psychiatrist as defined in these rules and delivered by an interdisciplinary team of board-certified or board-eligible child and adolescent psychiatrists, registered nurses, psychologists, other qualified mental health professionals, and other relevant program staff. A psychiatrist shall be available to the unit 24-hours per day, seven days per week.

(c) Psychiatric Residential Treatment Services shall be staffed to the acuity and severity of admitted children at a staffing ratio of not less than one staff for three children during the day and evening shifts. At least one staff for every three staff members during the day and evening shifts shall be a Qualified Mental Health Professional or Qualified Mental Health Associate. For overnight staff there shall be a staffing ratio of at least one staff for six children with one being a Qualified Mental Health Associate. For units that by this ratio have one overnight staff, there shall be additional staff immediately available within the facility or on the premises. At least one Qualified Mental Health Professional shall be on site or on call at all times. At least one staff with designated clinical leadership responsibilities shall be on site at all times.

(4) Sub-Acute Psychiatric Care. These are services provided by nationally accredited providers certified under these rules for children who need 24-hour intensive mental health treatment in a secure setting to assess, evaluate and stabilize or resolve the symptoms of an acute episode that occurred as the result of the diagnosed mental disorder. In addition to the requirements provided in 309-032-1150(1)–(3) Sub-Acute Psychiatric Care providers shall:

(a) Provide psychiatric nursing staffing at least 16 hours per day;

(b) Establish policies and practices to meet the following admission and continued stay criteria:

(A) Admission:

(i) The child is admitted by physician order for a period up to 14 days to determine through assessment and evaluation the existence of a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis that shall be the basis for the development of a plan to guide the child's treatment; or

(ii) The child has a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis; and

(iii) The child needs treatment 24-hours each day in a secure setting under the direction of a psychiatrist to stabilize or resolve symptoms or behaviors which were identified as the reason for admission and which are consistent with the DSM diagnosis;

(iv) The admitting and referring physicians have consulted and agree on the admission;

(v) Proposed treatments for the DSM diagnosis require close nursing supervision and monitoring and psychiatric supervision at least one to three times per week; and

(vi) Less restrictive or less intensive services cannot be expected to improve the child's condition or prevent further regression so that Sub-Acute services will no longer be needed.

(B) Continued Stay:

(i) Children shall remain in Sub-Acute Psychiatric Care only as long as necessary to provide brief treatment to stabilize the child. Continued stays of more than 30 days shall be approved at 30-day intervals up to 90 days by the Division or its designated external review organization.

(ii) Children may continue to receive Sub-Acute Psychiatric Care services for more than 90 days only by authorization of the attending psychiatrist or the interdisciplinary team and approval by the Division or its designated external review organization.

(c) Mechanical restraint shall be used only by Sub-Acute providers specifically authorized by the Division in writing to use mechanical restraint.

(5) Assessment and Evaluation Programs. Assessment and Evaluation Programs shall provide services for children who need up to 90 days of 24-hour comprehensive mental health assessment to diagnose a mental disorder and to stabilize assessed symptoms and behavior that affect the child's functioning. In addition to the requirements provided in 309-032-1150(1) and (2) providers of assessment and evaluation program services shall establish policies and practices to meet the following admission and continued stay criteria:

(a) Admission:

(A) The child is admitted by physician order for a period up to 30 days to assess, evaluate and make written recommendations for continuing services. If the child is determined to have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis that shall be the basis to guide the child's treatment; or

(B) The child has a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis; and

(C) The child needs additional assessment and brief active treatment 24 hours each day under the direction of a psychiatrist to stabilize or resolve symptoms or behaviors which were identified as reason for admission and which are consistent with the DSM diagnosis; and

(D) Less restrictive or less intensive services cannot be expected to improve the child's condition or prevent further regression so that residential assessment and evaluation services will no longer be needed.

(b) Continued Stay:

(A) Children shall remain in an Assessment and Evaluation program only for the period of time needed to complete the necessary battery of assessments and provide brief treatment to stabilize the child.

(B) Continued stays of more than 30 days shall be approved at 30-day intervals up to 90 days by the Division or its designated external review organization.

(C) Children may continue to receive Assessment and Evaluation services for more than 90 days only by authorization of the attending psychiatrist or the interdisciplinary team and approval by the Division or its designated external review organization.

(c) Assessment and Evaluation programs shall provide the referring source with written discharge instructions, a comprehensive written assessment and recommendations for continuing care at the conclusion of the assessment period.

(6) Residential Psychiatric Treatment Program. Services shall include 24-hour supervision for children who have a serious psychiatric, emotional and/or acute behavioral health issues which require intensive therapeutic counseling and activity, intensive staff supervision, support and assistance. In addition to the requirements provided in 309-032-1150(1)–(3) a Residential Psychiatric Treatment Program shall establish policies and practices to meet the following admission and continued stay criteria:

(a) Admission:

(A) A psychiatric or psychological evaluation including a completed 5-axis diagnosis current within 60 days of the application date. The child shall have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis. The referral information shall have been reviewed by an independent psychiatric review process established by the Division to certify the need for services based on the following criteria:

(B) Ambulatory resources available in the community do not meet the child's treatment needs;

(C) Proper treatment of the child's psychiatric condition requires services on a 24-hour intensive treatment basis under the direction of a psychiatrist;

(D) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary;

(E) Providers shall accept an emergency admission only under unusual and extreme circumstances. Emergency admissions shall be retrospectively reviewed by the Division or its designated external review organization.

(b) Continued Stay:

(A) Children shall remain in a 24-hour Residential Psychiatric Treatment Program only for the period of time determined to be medically appropriate to treat the psychiatric condition(s) identified on the child's individual plan of care.

(B) Continued stays shall be approved by the Division or its designated external review organization at 90-day intervals.

(C) Continued stays that exceed one year and at an annual basis thereafter shall be approved by the Division or a designated external psychiatric review process.

(7) Psychiatric Residential Treatment Facility. Services shall include 24-hour supervision for children who have a serious psychiatric, emotional and/or behavioral health issues which require intensive therapeutic counseling and activity, staff supervision, support and assistance. These services are associated with a Psychiatric Residential Treatment Program for children who can benefit from a less restrictive residential environment. In addition to the requirements provided in 309-032-1150(1)–(3) a Psychiatric Residential Treatment Facility shall:

(a) Be staffed to the acuity and severity of admitted children and have sufficient QMHP staff to ensure delivery of the appropriate mix and frequency of sound clinical treatment services. There shall be no less than one QMHP for the first five children enrolled. For each additional group of five, or any part thereof, a QMHP or QMHA will be added to the treatment staff ratio. At least one staff per every five staff members shall be a QMHP. For overnight staff there shall be a staffing ratio of at least one staff for six children with one being a QMHA. For units that by this ratio have one overnight staff, there shall be additional staff immediately available within the facility or on the premises. At least one QMHP shall be on site or on call at all times. At least one staff with designated clinical leadership responsibilities shall be on site at all times.

(b) Admission criteria:

(A) The admission decision shall be the responsibility of the interdisciplinary team based on referral information current within the last 60 days;

(B) The referral information shall have been reviewed by an independent psychiatric review process established by the Division to certify the need for services based on the following criteria:

(i) Ambulatory resources available in the community do not meet the child's treatment needs;

(ii) Proper treatment of the child's psychiatric condition requires services on a 24-hour intensive treatment basis under the direction of a psychiatrist but is less severe than the need for Residential Psychiatric Treatment Program level of care;

(iii) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.

(c) Continued Stay:

(A) Children shall remain in a 24-hour Psychiatric Residential Treatment Facility only for the period of time determined to be medically appropriate to treat the psychiatric condition(s) identified on the child's individual plan of care.

(B) Continued stays shall be approved by the Division or its designated external review organization at 90-day intervals.

(C) Continued stays that exceed one year and at an annual basis thereafter shall be approved by the Division or a designated external psychiatric review process.

(8) Partial Hospitalization Programs. Partial Hospitalization services shall be delivered by nationally accredited providers certified under these rules to provide day hospital services. Partial Hospitalization services shall be provided to children who can be maintained at home by a parent, guardian or foster parent by qualified mental health professionals and qualified mental health associates under the direction of a psychiatrist.

(a) Partial Hospitalization services providers shall maintain one or more contracts with acute care hospitals and/or MHOs to coordinate necessary inpatient care with the MHOs and their contracted hospitals. Partial Hospitalization providers shall maintain linkages with primary care physicians, CMHPs and MHOs, and the child's parent(s) or guardian to plan for necessary continuing care resources for the child.

(b) Partial Hospitalization programs shall be staffed to the acuity and severity of admitted children at a clinical staffing ratio of at least one Qualified Mental Health Professional or Qualified Mental Health Associate for up to three children. And have the 24-hour on-call availability of at least one Qualified Mental Health Professional during hours the program is not open.

(c) Providers of Partial Hospitalization services shall establish policies and practices to meet the following admission, continued stay and discharge criteria:

(A) Admission:

(i) The admission decision shall be the responsibility of the interdisciplinary team. The admission shall be based on referral information current within the last 60 days.

(ii) The child shall have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis and the referral information shall have been reviewed by a psychiatric review process established by the Division to certify the need for services based on the following criteria:

(I) Partial Hospitalization level of care is appropriate to meet the child's treatment needs;

(II) Proper treatment of the child's psychiatric condition requires intensive treatment services under the direction of a psychiatrist; and

(III) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.

(B) Continued Stay:

(i) Children shall remain in a Partial Hospitalization program only for the period of time determined to be medically appropriate to treat the psychiatric conditions identified on the child's individual plan of care.

(ii) Continued stays shall be reviewed by the interdisciplinary team and approved every 30 days by a Division approved process.

(9) Psychiatric Day Treatment. Psychiatric Day Treatment services are delivered by providers certified by the Division under these rules to provide Psychiatric Day Treatment services. Psychiatric Day Treatment services shall be provided to children who can be maintained at home by a parent, guardian or foster parent by qualified men-

tal health professionals and qualified mental health associates in consultation with the psychiatrist. An education program is provided and admitted children shall have, or have been screened for, an Individual Education Plan, Personal Education Plan or Individual Family Service Plan.

(a) Psychiatric Day Treatment programs shall be staffed to the acuity and severity of admitted children at a clinical staffing ratio of at least one Qualified Mental Health Professional or Qualified Mental Health Associate for three children.

(b) Providers of Psychiatric Day Treatment services shall establish policies and practices to meet the following admission, and continued stay criteria:

(A) Admission:

(i) The admission decision shall be the responsibility of the interdisciplinary team. The admission shall be based on referral information current within the last 60 days.

(ii) The child shall have a primary diagnosis on Axis I of a completed 5-Axis DSM diagnosis and the referral information shall have been reviewed by a review process approved by the Division to certify the need for services based on the following criteria:

(I) Psychiatric Day Treatment level of care is appropriate to meet the child's treatment needs;

(II) Proper treatment of the child's psychiatric condition requires intensive treatment services in consultation with a psychiatrist; and

(III) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.

(B) Continued Stay:

(i) Children shall remain in a psychiatric day treatment program only for the period of time determined to be medically appropriate to treat the psychiatric conditions identified on the child's individual plan of care.

(ii) Continued stay shall be reviewed by the interdisciplinary team and approved every 90 days by a review process approved by the Division.

(10) Substitute Care Settings. Providers of community-based intensive mental health treatment services in substitute care settings shall be certified under these rules. These services include therapeutic group homes and treatment foster care homes. The provider delivers active mental health treatment focused on the behavior, feelings and perceptions the child presents in the treatment/living milieu through regularly scheduled group and individual skills training. Active treatment is based on a mental health assessment of the child's developmental level, behavior, functioning and the severity and acuity of psychiatric symptoms.

(a) Treatment services provided in therapeutic group home and treatment foster care settings shall be delivered by QMHPs and QMHAs with experience and training in psychosocial skills development and milieu therapy under the direction of a qualified mental health professional in consultation with an psychiatrist. The treatment staffing ratio shall be one staff for every eight children.

(b) Providers of therapeutic group home and treatment foster care services shall maintain linkages with primary care physicians, applicable education agencies, CMHPs and MHOs, SCF or OYA representatives, and the child's parent(s) or guardian to coordinate related services and aftercare resources for the child.

(c) Therapeutic group home and treatment foster care and other individualized intensive treatment services provided in substitute care settings shall be staffed to the acuity and severity of admitted children according to the treatment prescribed in each child's individual plan of care. The provision of these services shall be supervised by a Qualified Mental Health Professional.

(d) Providers shall establish policies and practices to meet the following admission and continued stay criteria:

(A) Admission shall be based on referral information current within the last 60 days and include a written assessment by a Qualified Mental Health Professional of the child's primary diagnosis on Axis I of a 5-Axis diagnosis supporting the following criteria:

(i) Therapeutic group or treatment foster care home mental health treatment level of care is appropriate to meet the child's treatment needs; and

(ii) The services can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary.

(B) Continued stay in a therapeutic group or treatment foster care home shall be based upon determination by an LMP of the medical appropriateness of the setting treating the psychiatric conditions identified in the child's individual plan of care.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1160
Establishing and Maintaining Clinical Records

(1) Individual record. A single, separate and individualized clinical record shall be maintained for each child served by the provider.

(2) Terminology. All documentation entries in the clinical record shall be written in commonly accepted clinical terms in standard, understandable English.

(3) Error corrections. Errors in the clinical record shall be corrected by lining out the incorrect data with a single line in ink, and then adding the correct information, the date corrected, and the initials of the person making the correction. Errors may not be corrected by removal or obliteration.

(4) Signature of authors. All documentation required in this rule must be signed by the person providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed. Documentation that is dictated shall also include the date of dictation and date signed.

(5) Organization of clinical records. Each clinical record shall be uniform in organization, readily identifiable and accessible, and contain all of the content required by these rules in a current and complete manner within required timelines.

(6) Providers shall insure that each clinical record includes the following documentation:

(a) MHOs, FCHP, or other third party insurance enrollment information;

(b) Identifying data including child's name, date of birth, gender, address, phone number and name of parent(s) or legal guardian including an address and phone number if different;

(c) A mental health assessment, comprehensive mental health assessment, diagnoses and clinical formulation;

(d) An individualized plan of care developed by the interdisciplinary team or professional;

(e) Written discharge criteria;

(f) Completed medical history including current prescribed medications and allergies;

(g) Emergency medical and dental resources and primary care physician;

(h) A medication service record of all medications administered;

(i) Documentation by the interdisciplinary team that the child's individual plan of care has been reviewed, the services provided are medically appropriate for the specific level of care, and changes in the plan recommended by the interdisciplinary team as indicated by the child's treatment needs have been implemented;

(j) Progress notes documenting specific treatments, interventions, and activities related to the individual plan of care or have treatment planning implications, and the child's response to the specific treatment or activities;

(k) Special treatment procedures notations in a separate section or in a separate format documenting each incident of manual restraint, seclusion, or mechanical, signed and dated by the staff directing the intervention and if required by the psychiatrist and/or clinical supervisor authorizing the intervention;

(l) Written discharge instructions and discharge summary; and

(m) The clinical documentation received from the referral source.

(7) The child's parent or guardian, or the child if legally emancipated, must give informed consent in writing to treatment including specific informed consent to the initial administration of any medication, or to a subsequent change in the class of the medication. Each informed consent shall state the information in writing, signed and dated by the person giving consent, and placed in the child's clinical record.

(8) The child's parent or guardian, or the child if legally emancipated, has the right to refuse treatment services including those generally accepted such as medication. The consequences of this service refusal shall be explained verbally and in writing by the provider to the child and parent or guardian, or the child if legally emancipated. A refusal of service shall be documented in the child's record.

(9) The child's clinical record shall be secured, safeguarded, stored and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(10) The child has the right to confidentiality when referenced in another child's clinical record.

(11) Providers that use electronic clinical record systems shall establish written policies and procedures to ensure confidentiality in accordance with ORS 179.505 through 179.507. The policies and procedures shall assure the following:

(a) The capacity to regularly provide printed documentation of all content incorporated within the clinical record;

(b) The verification of authentication of the individual making an entry including name, degree and date entered; and

(c) Safeguards to protect access to and the use of information contained in the electronic system.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1170
Child and Family Rights

Providers shall establish written policies and procedures pertaining to child and family rights. The written statement of rights shall be posted prominently in simple, easy to understand language on a form devised by the provider or the Division. This form shall be given by the provider to the person legally giving consent to treatment of the child, at the time of admission. In addition, these rights shall be explained orally at the time of admission to the person giving consent to treatment and to the child, in a manner appropriate to the child's developmental level. If the child is initially served in a crisis situation, these rights shall be explained as soon as clinically practical, but not more than five working days from the initiation of services if the child who received the crisis service remains in service. Statement of Rights shall include the following:

(1) Right to provide consent to treatment in accordance with ORS 109.640 and 109.675.

(2) Right to refuse services.

(3) Right to confidentiality in accordance with ORS 179.505, 107.154, and 418.312.

(4) Right to immediate inspection of the clinical record in accordance with ORS 179.505.

(a) The child, if able, and the custodial parent(s) or guardian of a minor child has the right to immediate inspection of the record.

(b) A copy of the record is to be provided within five working days of a request for it. The person requesting the record is responsible for payment for the cost of duplication, after the first copy.

(c) Identifying and clinical information about the child shall be protected in provider publications such as newsletters and brochures.

(5) Right to humane treatment in the least restrictive environment.

(6) Right to receive services in a humane environment that provides the child with protection from harm and protects the dignity of the child and his or her family.

(7) Right to participate in treatment planning. The child, to the extent of his or her capability, and the child's parent or guardian, shall have the right to participate in the planning of services, including the right to participate in the development and periodic revision of the child's individual plan of care. The child's attorney or other representative shall also have the right to participate in the planning process, including attending individual plan of care development and review meetings, upon the request of the child or child's parent or guardian.

(8) Right to private and uncensored communications by mail, telephone and visitation.

(a) This right may be restricted only if the treatment provider documents in the child's record that, in the absence of this restriction, significant physical or clinical harm will result to the child or others. The nature of the harm shall be specified in reasonable detail, and any restriction of the right to communicate shall be no broader than necessary to prevent this harm.

(b) The parent or guardian and the child, in a developmentally appropriate manner, shall be given specific written notice of each restriction of the child's right to communicate. The treatment provider shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible and allow for confidential communication, and that space is available for visits. Reasonable times for the use of telephones and visits may be established in writing by the treatment provider.

(c) A child shall have the right to uncensored communication with licensed attorneys at law and the state protection and advocacy agency.

(d) The state protection and advocacy agency shall be permitted access to a child and the child's records consistent with federal and state statutes and regulations governing such access. The child's juvenile court attorney and court appointed special advocate (CASA), if any, shall have access to the child and the child's records in accordance with applicable statutes and administrative rules.

(9) Right to personal possessions.

(a) A child shall have the right to wear his or her own clothing and to keep personal possessions. The provider must provide the child with a reasonable amount of storage space for this purpose.

(b) Possession and use, including reasonable restriction of the time and place of use, of certain classes of property may be restricted by the treatment provider if necessary to prevent the child or others from harm, provided that notice of this restriction is given to all children and their families upon the child's admission.

(c) An individual item not subject to general restriction but substantially likely to cause significant physical or clinical harm to a particular child or others due to the child's individual clinical condition may be restricted if the harm that would be likely to result is specifically documented in the child's record. The parent or guardian and the child, in a developmentally appropriate manner, shall be given specific written notice of each such restriction.

(10) Right to receive educational services in the least restrictive environment. Including, if the child is eligible, a free appropriate public education under the Individuals with Disabilities Education Act, 20 USC, Secs. 1401 et seq. Section 504 of the Rehabilitation Act of 1973, 29 USC Sec. 794, and related federal and state statutes and regulations.

(11) Right to refuse to perform routine labor tasks for the provider and to receive reasonable compensation for all work performed other than personal housekeeping duties or chores.

(12) Right to be free from unusual or hazardous treatment procedures and to not participate in experimental treatment procedures without voluntary informed consent.

(13) Right to be free from seclusion or restraint unless used in compliance with all applicable statutes and administrative rules.

(14) Right to freely exercise recognized and accepted religious beliefs and other civil rights.

(15) Right to be thoroughly informed of the provider's rules and regulations.

(16) Right to participate regularly in developmentally appropriate indoor and outdoor play and recreation.

(17) Right to make informed consent to fees for services. The amount and payment schedule of any fees to be charged must be disclosed in writing and agreed to by the person consenting to treatment.

(18) Right to consent to disclosure of clinical records. The person consenting to treatment, usually the custodial parent or guardian, has the right to authorize disclosure of the child's clinical record in accordance with ORS 179.505. When a child is admitted for treatment under a voluntary placement agreement with SCF, the parent(s) or guardian shall have the right to authorize disclosure.

(19) Right of assertion of rights. The rights contained in this section may be asserted and exercised by the child (except where the law requires that only the parent or guardian may exercise a particular right), the child's parent or guardian, or any representative of the child.

(20) Right of formal complaint. The child, parent or guardian or child's representative shall have the right to assert formal complaints concerning denial of any rights contained in this section in a fair, timely and impartial formal complaint procedure. There shall be no retaliation or punishment for exercise of any rights contained in this section.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
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Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1180
Behavior Management

(1) Providers shall have a written behavior management policy specifying which behavior management practices and restrictions may be used by staff and the circumstances under which they may be used. The behavior management policy shall:

(a) Establish a framework, which assures consistent behavior management practices throughout the program and articulates a rationale consistent with the provider's philosophy of treatment;

(b) Require the provider to obtain informed consent upon admission from the parent(s) or guardian in the use of behavior management practices and communicate both verbally and in writing the information to the parent(s) or guardian and the child in a developmentally appropriate manner;

(c) Establish thresholds and tracking mechanisms of behavior management interventions that will activate clinical review and which shall be relevant to the acuity and severity of symptoms, and developmental functioning of the population served by the provider;

(d) Require that when thresholds established in the policy are exceeded that the child's individual plan of care be reviewed and revised if necessary within no more than 24 hours and specifies the individual(s) in the program with designated clinical leadership responsibilities who must participate in the review, and specify that the review be documented in the child's clinical record;

(e) Describe the manner and regime in which all staff will be trained to manage aggressive, assaultive, maladaptive, or problem behavior and de-escalate volatile situations through a Division approved crisis intervention training program, and require that such training shall occur annually; and

(f) Require that the provider review and update behavior management policies, procedures, and practices, minimally annually.

(2) Individual behavior management interventions will be developed, implemented, and reviewed for each child, review shall occur minimally at each individual plan of care review.

(3) Each staff directed behavior management intervention that isolates a child for more than 15 minutes shall be noted in the child's clinical record:

(a) The cumulative data shall be reviewed by the child's interdisciplinary team and be reported in the next required individual plan of care review summary;

(b) The individual plan of care shall outline use of this procedure, therapeutic alternatives, and methods to reduce its use; and

(c) Assure that when incidents of isolation for more than five hours in five days or a single episode of two hours the psychiatrist or designee shall within 24 working hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1190
Special Treatment Procedures

(1) Providers shall have policies and procedures and a quality management system to:

(a) Monitor the use of special treatment procedures to assure that children are safeguarded and their rights are always protected; and

(b) Review and approve experimental practices other than medications that are outside usual and customary clinical practices and research projects. Experimental practices and research require review and approval by the Division Institutional Review Board.

(2) Chemical restraint shall not be used. Medication shall not be used as a restraint, but shall be prescribed and administered according to acceptable nursing, medical, and pharmaceutical practices to treat symptoms of serious emotional disorders.

(3) Mechanical restraint shall be used only in a Sub-Acute program specifically authorized for such use in writing by the Division. Sub-Acute programs that are authorized to use mechanical restraint shall adhere to the standards for special treatment procedures as described in this section and other specific conditions as required by the Division.

(4) The provider shall establish a Special Treatment Procedures Committee or designate this function to an already established Quality Management Committee. Committee membership shall minimally include a staff person with designated clinical leadership responsibilities, the person responsible for staff training in crisis intervention procedures, and other clinical personnel not directly responsible for authorizing the use of special treatment procedures with individual children. The committee shall:

(a) Meet at least monthly and shall report in writing to the provider's Quality Management Committee at least quarterly regarding the committee's activities, findings and recommendations;

(b) Conduct individual and aggregate review of incidents of seclusion and manual restraint;

(c) Conduct individual and aggregate review of incidents of isolation for more than five hours in five days or a single episode of two hours;

(d) Analyze special treatment procedures to determine opportunities to reduce their use, increase the use of alternatives, improve the quality of care of children receiving services, and recommend whether follow up action is needed; and

(e) Review and update special treatment procedures policies and procedures minimally annually.

(5) Obtain informed consent upon admission from the parent(s) or guardian in the use of special treatment procedures. Communicate both verbally and in writing the information to the parent(s) or guardian and the child in a developmentally appropriate manner.

(6) General Conditions of Manual Restraint and Seclusion.

(a) There shall be a systematic approach, documented in written policies and procedures to the treatment of children which employs individualized, preplanned alternatives to manual restraint and seclusion;

(b) Manual restraint and seclusion shall only be used in an emergency to prevent immediate injury to a child who is in danger of physically harming him or her self or others in situations such as the occurrence of, or serious threat of violence, personal injury or attempted suicide;

(c) Any use of manual restraint and seclusion shall respect the dignity and civil rights of the child;

(d) A child shall be manually restrained or secluded only when clinically indicated and alternatives are not sufficient to protect the child or others as determined by the interdisciplinary team responsible for the child's individual care plan;

(e) The use of manual restraint and seclusion shall be directly related to the child's individual symptoms and behaviors and the acuity of the symptoms and behaviors. Manual restraint and seclusion shall not be used as punishment, discipline, or for the convenience of staff;

(f) Manual restraint and seclusion shall only be used for the length of time necessary for the child to resume self-control and prevent harm to the child or others;

(g) If manual restraint and seclusion are considered as part of the child's individualized safety needs, then alternatives to manual restraint and seclusion shall be identified and made a part of the child's individual plan of care. The individual plan of care shall outline use of this procedure, and goals addressing therapeutic alternatives and interventions to reduce its use; and

(h) Each incident of manual restraint and seclusion shall be referred to the Special Treatment Procedures Committee.

(A) Manual Restraint:

(i) Each incident of manual restraint shall be documented in the clinical record. The documentation shall specify less restrictive methods attempted prior to the manual restraint, the required authorization, length of time the manual restraint was used, the events precipitating the manual restraint, assessment of appropriateness of the manual restraint based on threat of harm to self or others, assessment of physical injury, and the child's response to the intervention;

(ii) A minimum of two staff shall implement a manual restraint. If in the event of an emergency a single staff manual restraint has occurred, the provider's on-call administrator shall immediately review the intervention;

(iii) A manual restraint intervention that exceeds 30 minutes shall require a documented review and authorization by a QMHP, interventions which exceed one hour shall require a documented review and authorization by a psychiatrist or designee; and

(iv) A designated individual with clinical leadership responsibilities shall review the manual restraint documentation prior to the end of the shift in which the intervention occurred.

(v) If incidents of manual restraint used with an individual child cumulatively exceed five hours in five days or a single episode of one hour, the psychiatrist or designee shall within 24 hours convene by phone or in person individual(s) in the program with designated

clinical leadership responsibilities to review the child's individual plan of care and/or behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.

(B) Seclusion:

(i) Each episode of seclusion shall be authorized immediately after initiation of the episode in the child's clinical record by the psychiatrist. A general order for the use of seclusion is not sufficient. The psychiatrist may delegate the authority to authorize seclusion to QMHP staff who have satisfactorily completed a Division-approved crisis intervention training program;

(ii) Written orders for seclusion are limited to two hours for children age nine and older and one hour for children under age nine. The psychiatrist may extend the original order for one additional hour for children under age nine to two hours total, and the original order for two hours for children age nine and older up to six hours total;

(iii) Visual monitoring of a child in seclusion shall occur and be documented at least every fifteen minutes or more often as clinically indicated;

(iv) The child's right to retain personal possessions and personal articles of clothing may be suspended during a seclusion only when necessary to ensure the safety of the child or others. Articles that a child might use to inflict self-injury must be removed;

(v) The child shall have regular meals, bathing, and use of the bathroom during seclusion and their provision shall be documented in the child's clinical record;

(vi) Each incident of seclusion shall be documented in the child's clinical record. The documentation shall include the clinical justification for use, the written order by the authorized individual, the less restrictive methods attempted, length of time the seclusion was used, the precipitating events, assessment of appropriateness of the intervention based on threat of harm to self or others, assessment of physical injury, and the child's response to the intervention; and

(vii) If incidents of seclusion used with an individual child cumulatively exceed five hours in five days or a single episode of more than two hours for children age nine and older and more than one hour for children under age nine, the psychiatrist or designee shall within 24 hours convene by phone or in person individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and/or behavior management interventions and make necessary adjustments. This information shall be documented in the child's clinical record and referred to the Special Treatment Procedures Committee.

(7) Application for the use of seclusion. Any facility or program in which the use of seclusion occurs shall be authorized by the Division for this purpose and shall meet the following requirements:

(a) A facility or program seeking authorization shall submit a written application to the Division;

(b) Application shall include a comprehensive plan for the need for and use of seclusion of admitted children and copies of the facility's policies and procedures for the utilization and monitoring of seclusion including a statistical analysis of the facility's actual use of seclusion, physical space, staff training, staff authorization, record keeping and quality management practices;

(c) The Division shall review the application and, after a determination that the written application is complete and satisfies all applicable requirements, shall provide for a review of the facility by authorized Division staff;

(d) The Division shall have access to the records of the facility's clients, the physical plant of the facility, the employees of the facility, the professional credentials of employees, and shall have the opportunity to observe fully the treatment and seclusion practices employed by the facility;

(e) After the review, the Assistant Administrator or designee shall approve or disapprove the facility's application and if, approved, shall certify the facility based on the determination of the facility's compliance with all applicable requirements for the seclusion of children;

(f) If disapproved the facility shall be provided with specific recommendations and have the right of appeal to the Division; and

(g) Certification of a facility shall be effective for a maximum of three years and may be renewed thereafter upon approval of a renewal application.

(8) Structural and physical requirements for seclusion. Any facility or program in which the use of seclusion occurs shall be certified by the Division for this purpose. A provider seeking this certification under these rules shall have available at least one room that meets the following specifications and requirements:

(a) The room must be of adequate size to permit three adults to move freely and allows for one adult to lie down. Any newly constructed room shall be no less than 64 square feet;

(b) The door must open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside;

(c) The room shall contain no protruding, exposed, or sharp objects;

(d) The room shall contain no furniture. A fireproof mattress or mat shall be available for comfort;

(e) Any windows shall be made of unbreakable or shatterproof glass, or plastic. Non-shatterproof glass shall be protected by adequate climb-proof screening;

(f) There shall be no exposed pipes or electrical wiring in the room. Electrical outlets shall be permanently capped or covered with a metal shield secured by tamper-proof screws. Ceiling and wall lights shall be recessed and covered with safety glass or unbreakable plastic. Any cover, cap or shield shall be secured by tamper-proof screws;

(g) The room shall meet State Fire Marshal fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with fine mesh screening. If pop-down type, sprinklers must have breakaway strength of under 80 pounds. In lieu of sprinklers, combined smoke and heat detector shall be used with similar protective design or installation;

(h) The room shall be ventilated, kept at a temperature no less than 64°F and no more than 85°F. Heating and cooling vents shall be secure and out of reach;

(i) The room shall be designed and equipped in a manner that would not allow a child to climb off the ground;

(j) Walls, floor and ceiling shall be solidly and smoothly constructed, to be cleaned easily, and have no rough or jagged portions; and

(k) Adequate and safe bathrooms shall be available.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1200
Quality Management

Providers shall have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to children and families. The Quality Management system shall include a Quality Management Committee and a Quality Management Plan which together implement a continuous cycle of assessment and improvement of clinical outcomes based on measurement and input from service providers and representatives of the children and families served.

(1) Providers shall have a continuous quality management process that:

(a) Establishes and reviews expectations about quality and outcomes; and

(b) Seeks to correct any observed deficiencies identified through its quality management process.

(2) The overall scope of the Quality Management process is described in a written plan which identifies mechanisms, committees or other means of assigning responsibility for carrying out and coordinating the Quality Management process activities, and which includes:

(a) Indicators of quality;

(b) Methods of monitoring;

(c) Reporting of results; and

(d) Follow-up mechanisms.

(3) The written Quality Management Plan shall describe the implementation and ongoing operation of the functions performed by the Quality Management Committee.

(a) The plan shall be reviewed and revised annually; and

(b) The provider's board shall review the annual Quality Management report and approve the annual Quality Management plan.

(4) The Quality Management Plan shall include:

(a) A description of the Quality Management Committee's authority to identify and implement clinical and organizational changes;

(b) The composition and tenure of the Quality Management Committee;

(c) The schedule of Quality Management Committee(s) meetings;

(d) Provisions which require activities to evaluate and recommend improvements as necessary in the following domains:

(A) Quality of care provided to children and families;

(B) Integration and coordination of services between the provider and other entities associated with the child and family;

(C) Child and parent and/or guardian satisfaction; and

(D) Clinical outcomes.

(e) The requirements that the following review activities are conducted and integrated into the overall Quality Management process:

(A) Review of the use of special treatment procedures;

(B) Review of grievances, formal complaints, incidents or accidents; and

(C) Review of problems with the administration or prescription of medications.

(5) The provider shall have a Quality Management Committee that meets at least quarterly. The Quality Management Committee shall be composed of:

(a) One or more qualified mental health professionals who are representative of the scope of services delivered;

(b) A representative or representatives of the children and families served;

(c) Other persons who have the ability to identify, design, measure, assess and implement clinical and organizational changes; and

(d) A representative of external agencies.

(6) Quality Management activities are conducted with representation of those who have knowledge or ability to effect continuous quality improvement.

(7) The Quality Management process is conducted with input from children, families, and community stakeholders.

(8) The provider has a participatory process whereby all personnel contribute to and recommend changes in the Quality Management process.

(9) The provider assures that the psychiatrist participates and is involved in quality management activities and is recognized within the staff organization as a member of the quality management committee with responsibilities described in the provider's quality management plan.

(10) Quality Management activities are conducted in accord with the applicable Oregon Revised Statutes, Oregon Administrative Rules and the provider's policies and procedures with regard to confidentiality.

(11) Documentation of the pertinent facts and conclusions of each Quality Management Committee meeting shall be maintained and be available for review by the Division.

(12) An annual report of Quality Management activities and data shall be available for review by the Division.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1210
Formal Complaints

(1) The child, or the person consenting to the child's treatment, has the right to file an oral or written formal complaint with the entity providing services and receive a timely response. All providers will:

(a) Have written procedures for accepting, processing and responding to oral or written formal complaints. The written procedures must include:

(A) The process for registering an oral or written formal complaint;

(B) The time lines for processing an oral or written formal complaint; and

(C) Notification of the appeals process, including time lines for a formal complaint and the provision of the appropriate appeal forms.

(b) Designate a staff person to coordinate formal complaint information, receive formal complaint information, assist any person who needs assistance with the process, and enter the information into a log. The log will identify, at a minimum, the person lodging the formal complaint, the date of the formal complaint, the nature of the formal complaint, the resolution and the date of the resolution.

(c) Have written procedures for informing children and their legal guardian orally and in writing about the provider's formal complaint procedures.

(d) Have written procedures for processing an expedited formal complaint request if it is believed the child's health is at risk. A request for expedited formal complaint must be filed by the child or the person consenting to the child's treatment and must include the following:

(A) A statement requesting an expedited formal complaint;

(B) An explanation of the urgency of resolving the issue; and

(C) A description of the consequences of following the regular formal complaint process.

(2) Service denial. The child, or the person consenting to treatment on behalf of the child, has the right to appeal when a service has been denied. All providers shall have written policies and procedures in compliance with applicable Oregon Medical Assistance Program Administrative Rules for accepting, processing and responding in writing within five working days to service denial complaints. The written response must include:

(a) The service requested;

(b) A statement of service denial;

(c) The basis for the denial; and

(d) Notification of the appeals process including the required time frame to file an appeal and provision of the appropriate appeal forms.

(3) Hearing request for Medicaid and CHIP eligible children. In accordance with applicable Oregon Administrative Rules, providers shall have a written appeals process whereby a Medicaid or CHIP eligible child, or the person consenting to treatment for the child, can assert his or her right to file a request for hearing as a result of a denial of service or an adverse finding against the complainant.

(4) Hearing request for children who are not Medicaid or CHIP eligible. Providers shall have a written appeals process for non-Medicaid, non-CHIP eligible children with at least one level of appeal at the provider level. The appeals process must culminate in a hearing by the Division Administrator or designee if the complaint cannot be satisfactorily resolved at the provider level.

Stat. Auth.: ORS 430.041, 430.640(1)(h) & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1220
Certificate of Approval

(1) Providers shall be in compliance with these rules and hold a valid Certificate of Approval issued by the Division to provide children's intensive mental health treatment services as described in these rules.

(2) A provider who is determined by the Division to be in substantial compliance with these rules may receive a Certificate of Approval valid for up to three years.

(3) A provider who is determined by the Division to be not in substantial compliance with these rules may, at the discretion of the Division, receive a time-limited Certificate of Approval of less than three years and may have conditions for compliance placed on the Certificate of Approval.

(4) The Division may require a provider who is not in compliance with these rules to develop a Plan of Correction within a time period specified by the Division. The Division may accept, reject, or modify the Plan of Correction or require the provider to comply with a Plan of Correction directed and approved by the Division.

(5) The Division at its discretion may terminate the provider's Certificate of Approval to provide children's intensive mental health treatment services, withhold funds, or apply other applicable sanctions allowable in rule and statute for failure to comply with these rules.

Stat. Auth.: ORS 430.041, 743.556 & 430.640(1)(h)
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

309-032-1230
Variance

A variance from portions of these rules that are not derived from federal regulations or the Office of Medical Assistance Program (OMAP) General Rules may be granted for a period of up to one year or a time period specified on the provider's Certificate of Approval in the following manner:

(1) The provider shall submit to the Assistant Administrator of the Division a written request which includes:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed; and

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(2) The Assistant Administrator of the Division shall approve or deny the request for variance in writing.

(3) The Division shall notify the provider of the decision in writing within 30 days of the receipt of the request.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division whose decision shall be final.

(5) All variances must be reapplied for as directed by the Division.

Stat. Auth.: ORS 430.041, 743.556 & 430.640(1)(h)
Stats. Implemented: ORS 430.630
Hist.: MHD 6-2000, f. & cert. ef. 2-15-00

Standards for Children's Intensive Community-Based Treatment and Support Services

309-032-1240
Purpose

These rules prescribe standards and procedures for providers of intensive community-based treatment and support services within the continuum of mental health care for children with serious mental, emotional, and behavioral disorders and their families. These rules apply to any certified provider of Community Mental Health Treatment Services for Children and to any certified provider of Children's Intensive Mental Health Treatment Services who are also certified as providers of Intensive Community-Based Treatment and Support Services. Children will be referred to providers certified under these rules based on a Level of Need Determination. The planning and provision of intensive community-based treatment and support services must promote collaboration between families as equal partners with providers and community resources in determining how best to meet the mental health needs of the child and family. These rules set standards for the provision of intensive psychiatric and mental health services and supports that are individualized, comprehensive, coordinated, child-centered, family-driven and culturally competent. The planning and provision of intensive community-based treatment and support services must ensure that the child and family are served in the most natural setting possible and disruptions to the child's school and home life are minimized. The goals of the service planning process are to build on child and family strengths in providing services that are directed toward successful home, school, and community functioning. Service planning must be flexible and responsive to the type, intensity, location, and duration of psychiatric and mental health services and supports that would benefit the child and family.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1245
Definitions

Definitions as used in these rules:

(1) "Behavior support plan" means the individualized strategies and techniques that are used by the family and providers to facilitate positive behavioral change in the child.

(2) "Behavior support policy" means the written policies and procedures adopted by the provider that describe the behavioral interventions and practices that may be used by the provider to support a child who is receiving services from the provider to manage his or her maladaptive or problem behavior.

(3) "Care coordination" means a process oriented activity that provides ongoing communication and collaboration with children and families with multiple needs. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

(4) "Case management" means a goal oriented activity that assists children, youth, and families. Case management includes: identifying strengths and needs; identifying, brokering and linking to community services and resources; assisting in obtaining entitlements; advocating on behalf of families; providing support and consultation to families; facilitating access to intensive services; and providing crisis planning, prevention, and intervention services.

(5) "Child" or "Children" means a person or persons under the age of 18, or for those with Medicaid eligibility under the age of 21, who receives ICTS services.

(6) "Child and family team" means those individuals who are responsible for creating, implementing, reviewing, and revising a service coordination plan. At minimum the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.

(7) "Clinical supervision" means the documented oversight by a Clinical Supervisor of mental health treatment services provided by Qualified Mental Health Professionals, Qualified Mental Health Associates, or mental health paraprofessionals. Clinical Supervision includes evaluating the effectiveness of the mental health treatment services provided. Clinical Supervision is performed on a regular, routine basis.

(8) "Clinical Supervisor" means a Qualified Mental Health Professional with two years post-graduate clinical experience in a mental health treatment setting. The clinical supervisor, as documented by the provider, operates within the scope of his or her practice or licensure, and demonstrates the competency to oversee and evaluate the mental health treatment services provided by other Qualified Mental Health Professionals, Qualified Mental Health Associates, or mental health paraprofessionals.

(9) "Community Mental Health Program" or "CMHP" means an organization that provides all services for persons with mental or emotional disorders, drug abuse problems, developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, as provided in ORS 430.630(10) or a local public health authority as provided in ORS 431.375, and operated in a specific geographic area of the state under an omnibus contract with the Department of Human Services.

(10) "Comprehensive mental health assessment" means the written documentation by a QMHP of the child's presenting mental health problem(s) and mental status, and evaluation of the child's functioning in the following domains: emotional, cognitive, family, developmental, behavioral, social, physical health, nutritional, school or vocational, substance use, cultural, spiritual, recreational, and legal. A comprehensive mental health assessment is collected through interview with the child, family and other relevant persons; review of previous treatment records; observation; and psychological and neuropsychological testing when indicated. The comprehensive mental health assessment concludes with a completed DSM five axis diagnosis, clinical formulation, prognosis for treatment, and treatment recommendations. The comprehensive mental health assessment is used to document the need for mental health services and to develop or update the child's treatment plan.

(11) "Comprehensive mental health assessment update" means the written documentation by a QMHP of the most current information related to all domains of a Comprehensive Mental Health Assessment.

(12) "Department" means the Department of Human Services.

(13) "Discharge criteria" means the diagnostic, behavioral, and functional indicators that, when met, means that service is complete. Discharge criteria must be documented in the child's mental health treatment plan.

(14) "Discharge summary" means written documentation of the last service contact with the child. Documentation must include the diagnosis at enrollment, and a summary statement that describes the effectiveness of treatment modalities and progress, or lack of progress, toward treatment objectives as documented in the mental health treatment plan. The discharge summary also includes the reason for discharge, changes in diagnosis during treatment, current level of functioning, prognosis, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.

(15) "DSM" means the text revision of the 4th edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-IV-TR) published by the American Psychiatric Association.

(16) "Evidence-based practice" or "EBP" means clinical and preventive mental health services that are based on the most current information from generally accepted scientific research and approved by OMHAS.

(17) "Family" means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, caregivers and other primary relations to the child whether by blood, adoption, legal or social relationship.

(18) "Family support" means the provision of supportive services. It includes: support to caregivers at community meetings; assistance to families in system navigation and managing multiple appointments; supportive home visits; peer support, parent mentoring and coaching; advocacy; and furthering efforts to develop natural and informal community supports.

(19) "Guardian" means a parent, other person or agency legally in charge of the affairs of a minor child and having the authority to make decisions of substantial legal significance concerning the child.

(20) "ICTS discharge criteria" means the written diagnostic, behavioral, and functional indicators the child and family will meet to transition out of ICTS services as documented in a child's service coordination plan.

(21) "ICTS discharge summary" means a written document developed by the child and family team that is completed prior to discharge from intensive community-based treatment and support services that is based on the service coordination plan. It includes: a review of service coordination planning; type and duration of services, supports, and levels of care utilized; concerns that arose during the planning process; and significant child and family accomplishments. The summary will also include recommendations about and planning to coordinate access to ongoing services and supports that would benefit the child and family as well as any other transition planning that will ensure continuity of care.

(22) "Informed consent to treatment" means that the information about a specific diagnosis and the risks or benefits of treatment options and the consequences of not receiving a specific treatment are understood by the child, if able, and the parent or guardian, if involved. The person consenting to treatment voluntarily agrees in writing, as required in ORS 430.210(d), to a prescribed treatment for the specific diagnosis.

(23) "Intensive community-based treatment and support services" or "ICTS" means a specialized set of in-home and community-based supports and mental health treatment services that are delivered in the most normative, least restrictive setting. Intensive community-based treatment and support services include, but are not limited to: crisis prevention and intervention; care coordination; case management; individual, group and family therapy; psychiatric services; skills training; family support; respite care; and team-driven service coordination planning.

(24) "Intensive treatment services" or "ITS" means a specific range of service components in the system of care. Intensive treatment services include treatment foster care, therapeutic group homes, psychiatric day treatment, partial hospitalization, psychiatric residential treatment, sub-acute care or other services as determined by OMHAS that provide active psychiatric and mental health treatment for children with severe emotional disorders and their families.

(25) "Level of care" means the relative amount and intensity of mental health services provided from the least restrictive and least intensive in a community-based setting to the most restrictive and most intensive in an inpatient setting. Children are to be served in the most normative, least restrictive, least intrusive level of care appropriate to their treatment history, degree of impairment, current symptoms and the extent of family or other supportive involvement.

(26) "Level of need determination" means the OMHAS approved process by which children are assessed for medically appropriate mental health treatment.

(27) "Licensed Medical Practitioner" or "LMP" means a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

(28) "Local Mental Health Authority" or "LMHA" means one of the following entities:

(a) The board of county commissioners of one or more counties that establishes or operates a community mental health and developmental disabilities program;

(b) The tribal council, in the case of a federally recognized tribe of Native Americans, that elects to enter into an agreement to provide mental health services; or

(c) A regional local mental health authority comprised of two or more boards of county commissioners.

(29) "Medically appropriate" means services, which are required for prevention (including preventing a relapse), diagnosis or treatment of mental health conditions. Services are appropriate and consistent with the diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental condition; appropriate with regard to standards of good practice; and generally recognized by the relevant scientific community as effective. Services are not solely for the convenience of the provider of the services, child or family; and are the most cost effective of the alternative levels of services, which can be safely and effectively provided to the child and family.

(30) "Mental Health Organization" or "MHO" means an entity under a risk-bearing contract with OMHAS to provide mental health services on a prepaid, capitated basis.

(31) "Mental status exam" means the face-to-face assessment by a QMHP of a child's mental functioning within a developmental and cultural context. It includes descriptions of appearance, behavior, speech, language, mood and affect, suicidal or homicidal ideation, thought processes and content and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, concentration, general knowledge, intellectual ability, abstraction abilities, judgment, and insight appropriate to the age of the child.

(32) "Office of Mental Health and Addiction Services" or "OMHAS" means the program office of the Department of Human Services responsible for the administration of mental health and addiction services for the State of Oregon.

(33) "Paraprofessional" means a family member, peer, natural support, or other person whose education, experience, and competence are adequate to permit them to provide direct mental health services such as family support and respite care to children, youth, and families under the supervision of a QMHP.

(34) "Qualified Mental Health Associate" or "QMHA" means a person who delivers services under the direct supervision of a Qualified Mental Health Professional and who meets the following minimum qualifications as documented by the provider:

(a) Has a bachelor's degree in a behavioral sciences field, or a combination of at least three years work, education, training or experience; and

(b) Has the competency necessary to:

(A) Communicate effectively;

(B) Understand mental health assessment, treatment and service terminology and to apply the concepts;

(C) Provide psychosocial skills development; and

(D) Implement interventions as assigned on a treatment plan.

(35) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner or any other person who meets the following minimum qualifications as documented by the provider:

(a) Holds any of the following educational degrees:

(A) Graduate degree in psychology;

(B) Bachelor's degree in nursing and licensed by the State of Oregon;

(C) Graduate degree in social work;

(D) Graduate degree in a behavioral science field;

(E) Graduate degree in recreational, music, or art therapy;

(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon.

(b) Whose education and experience demonstrate the competency to: identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a treatment plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family and/or group therapy within the scope of their training.

(36) "Respite care" means planned and emergency interventions designed to provide temporary relief from care giving in order to main-

tain a stable and safe living environment. Respite care can be provided in or out of the home and includes supervision of and behavioral support for the child.

(37) "Service coordination plan" means a written summary document that incorporates and supports the relevant plans, services, and supports that are being provided to the child and family by the providers, agencies, and others who comprise the child and family team as well as defining roles and responsibilities of each party. The service coordination plan is formulated by the team and approved by the family.

(38) "Service intensity" means the relative amount, frequency, intensity, and duration of mental health services provided to a child and family that is based on the assessed needs of the child and family specific to the child's diagnosis, level of functioning, and the acuity and severity of the child's psychiatric symptoms.

(39) "Skills training" means providing parenting information and behavior support training and planning to parents or caregivers as well as skills development for children and transitional youth. It may include developing and strengthening competencies that include but are not limited to areas such as anger management, stress reduction, conflict resolution, self-esteem, parent-child interactions, peer relations, drug and alcohol awareness, behavior support, managing symptoms, and adapting the home and other settings to mitigate triggers to maladaptive behavior. The goal of this service is to maintain a stable living environment, positive interpersonal relationships, and participation in developmentally appropriate activities.

(40) "Treatment plan" means the written plan developed jointly by the QMHP and the child with his or her family, if appropriate. The treatment plan specifies the DSM diagnosis, goals, measurable objectives, specific treatment modalities and evidence-based practices. It is based on a completed comprehensive mental health assessment or assessment update of the child's functioning and the acuity and severity of psychiatric symptoms.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1250
General Conditions of Participation for Children's Intensive Community-Based Treatment and Support Services Providers

Providers delivering or ensuring the provision of children's intensive community-based treatment and support services must:

(1) Hold a valid Certificate of Approval issued by the Office of Mental Health and Addiction Services (OMHAS) to deliver intensive community-based treatment and support services, and, when applicable, a license or certification from the Department of Human Services, State Office for Children, Adults, and Families;

(2) Maintain the organizational capacity and interdisciplinary treatment capability to deliver or ensure the provision of medically appropriate services to meet the assessed needs for treatment in the amount, intensity, and duration for each child specific to the child's diagnosis, level of functioning and the acuity and severity of the child's psychiatric symptoms;

(3) Use evidence-based treatment methods appropriate for children with severe mental, emotional, or behavioral disorders and professional standards of care;

(4) Assure that mental health services are provided under clinical supervision;

(5) Maintain policies describing procedures for admission, transition, and discharge;

(6) Demonstrate family involvement and participation in all phases of assessment, service planning and the child's treatment by documentation in the child's clinical record. At a minimum there must be documentation that all completed assessments have been reviewed and explained to the family or youth of legal age and to the child in a developmentally appropriate fashion;

(7) Maintain a formal relationship with a family organization for the purpose of assuring that family voice is part of all decision making and planning for the development of services, quality assurance, and use of resources. The formal relationship includes the following:

(a) The relationship is defined in a written agreement; and

(b) Family representation is included on governing and advisory bodies in numbers that result in meaningful participation.

(8) Develop a policy on family involvement that includes specific supports to family members that address and prevent barriers to family involvement;

(9) Report suspected child abuse as required in ORS 419B.010;

(10) Enroll children in Client Process Monitoring System when the child's mental health services are funded all or in part by OMHAS funds;

(11) Maintain policies and procedures prohibiting on- or off-site non-professional relationships and activities between employees and children and their families unless the activities are approved by the provider and interdisciplinary team and identified as clinically appropriate services in the child's service plan;

(12) Provide services for children in a smoke free environment in accordance with Public Law 103.277, the Pro-Child Act;

(13) Demonstrate education service integration in all phases of assessment, service planning, active treatment, and transition and discharge planning by documentation in the child's clinical record;

(14) Maintain policies and procedures to ensure safety and provide for the emergency needs of children, families, and staff including:

(a) Medical emergencies; and

(b) Facility and environmental emergencies.

(15) Demonstrate cultural competency, gender responsiveness and language appropriateness in the delivery of services to clients and their families;

(16) Demonstrate oversight by a governing body whose membership reflects diverse community interests and whose organization and operation must be set out in writing;

(17) Develop and publish a comprehensive document which describes the mission statement, treatment philosophy, including research or evidence basis for treatment models used, and program descriptions for the provision of intensive community-based treatment and support services; and

(18) Develop policies and procedures for orientation of children and families that consider orientation times convenient for the family and that provide for adequate child and family preparation.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1255
Award and Applicability of Certificates of Approval to Provide Children's Intensive Community-Based Treatment and Support Services

Certificates of Approval to provide children's intensive community-based treatment and support services may be applied for by a mental health services provider as defined in OAR 309-012-0140. The mental health services provider must either hold a valid Certificate of Approval issued by OMHAS to provide Children's Intensive Mental Health Treatment Services or a Certificate of Approval issued jointly by OMHAS and a CMHP to provide Community Mental Health Treatment Services for Children.

(1) Mental health services providers who hold a current and valid Certificate of Approval to provide children's intensive mental health treatment services may apply to OMHAS for a Certificate of Approval to provide intensive community-based treatment and support services. Applications must include evidence that the Local Mental Health Authority has been notified and has been given an opportunity to comment about the ITS provider's efforts to become ICTS certified and about the ITS provider's potential to serve children from the child's LMHA area. Certification of an ICTS provider can be effective for a maximum of three years and may be renewed thereafter by OMHAS.

(2) Mental health services providers who hold a current and valid Certificate of Approval to provide community treatment services for children may apply to the CMHPs to recommend that OMHAS issue a Certificate of Approval to provide intensive community-based treatment and support services. Certification of an ICTS provider can be effective for a maximum of three years and may be renewed thereafter by OMHAS.

(3) Following the completion of the application process, and any reviews deemed necessary by OMHAS or the CMHP, one of the following determinations will be made by OMHAS:

(a) That the applicant may be awarded a Certificate of Approval based on demonstration of its capacity and willingness to operate in compliance with applicable administrative rules;

(b) That the applicant will not be awarded a Certificate of Approval because it has not demonstrated that it will comply with applicable administrative rules; or

(c) That the applicant may be awarded a Certificate of Approval with specified conditions as described in OAR 309-012-0200 and at the discretion of OMHAS, receive a time-limited Certificate of Approval of less than three years and may have conditions for compliance placed on the Certificate of Approval to provide intensive community-based treatment and support services.

(4) OMHAS may require a provider who is not in compliance with these rules to develop a Plan of Correction within a time period specified by OMHAS. OMHAS may accept, reject, or modify the Plan of Correction or require the provider to comply with a Plan of Correction directed and approved by OMHAS.

(5) OMHAS, at its discretion, may terminate the provider's Certificate of Approval to provide intensive community-based treatment and support services, withhold funds, or apply other applicable sanctions allowable in rule and statute for failure to comply with these rules.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1260
Service Coordination Planning

ICTS providers must ensure that children and families referred to them through the level of need determination process receive care coordination when supported by the family. Providers must ensure that:

(1) A child and family team is identified and organized jointly with the family;

(2) A child and family team meeting is convened and an initial Service Coordination Plan, including any necessary crisis prevention and intervention planning, is developed no later than 14 calendar days from the date the provider receives an authorized request for ICTS services;

(3) The Service Coordination Plan is completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The plan is reviewed and revised quarterly, and when changes in service coordination planning occur, by the child and family team. It includes:

(a) A strengths and needs assessment that includes all relevant domains of the comprehensive mental health assessment;

(b) Short- and long-term goals related to identified needs across domains;

(c) Planning that utilizes a combination of existing or modified formal services; newly created services; informal, formal and natural supports and community resources; and documentation of the individuals responsible for providing these services and supports;

(d) A proactive safety/crisis plan that utilizes professional and natural supports to provide 24 hours, seven days per week flexible response and is reflective of strategies to avert potential crises without placement disruptions and provide appropriate interventions when crises occur; and

(e) ICTS discharge criteria as well as transition planning and coordination of the child's discharge from intensive community-based treatment and support services.

(4) The child receives medically appropriate mental health services and supports that include evidence-based practices, at the appropriate level of care, as determined by the ongoing service coordination planning by the child and family team; and

(5) Services and supports are documented in the child's clinical record.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1265
Intensive Community-Based Treatment and Support Services

ICTS providers must ensure that intensive community-based treatment and support services are made available to children and families referred to them through the level of need determination process. Services and supports must be provided by qualified individuals. Intensive community-based treatment and support services may be delivered at a clinic, facility, home, school, other provider/allied agency location or other setting as identified by the child and family team. Intensive community-based treatment and support services include but are not limited to:

(1) Providing or ensuring the provision of children's crisis services, which includes:

(a) 24 hours, seven days per week face-to-face or telephone screening to determine the need for immediate services for any child requesting assistance or for whom assistance is requested;

(b) 24 hours, seven days per week capability to conduct, by or under the supervision of a QMHP, a mental health status examination to determine the child's condition and the interventions necessary to stabilize the child;

(c) Provision of medically appropriate child and family, psychological, and psychiatric services necessary to stabilize the child;

(d) Referral to the appropriate level of care and linkage to other medically appropriate interventions necessary to protect and stabilize the child; and

(e) Linkage to appropriate social services.

(2) Comprehensive mental health assessment or assessment update.

(3) Psychiatric services provided by a Licensed Medical Practitioner.

(4) Medication management and monitoring.

(5) Individual, group and family therapy provided by a QMHP who has a child and adolescent mental health background and experience providing community-based, intensive services to families.

(6) Care coordination provided by a QMHP or QMHA supervised by a QMHP who has:

(a) Demonstrated competencies in child and adolescent mental health and experience providing intensive services to families;

(b) Extensive knowledge about services and resources available to children and families in the community;

(c) Experience facilitating service coordination meetings and collaborating with system partners; and

(d) Experience facilitating crisis prevention and intervention services.

(7) Case management provided by a QMHP or QMHA supervised by a QMHP who has:

(a) Demonstrated competencies in child and adolescent mental health and experience providing intensive services to families;

(b) Extensive knowledge about services and resources available to children and families in the community; and

(c) Experience facilitating crisis prevention and intervention services.

(8) Skills training provided by a QMHP or QMHA supervised by a QMHP who has:

(a) Demonstrated competency in child development, serious emotional and behavioral disorders and parenting-behavioral management;

(b) Extensive knowledge of community recreational, social and supportive resources; and

(c) Experience facilitating crisis prevention and intervention services.

(9) Family support and respite care provided by paraprofessionals who have:

(a) Specialized knowledge and experience that enables them to provide supportive services to families; and

(b) Received training that enables them to implement supportive services interventions to children and families coping with developmental, physical, medical, emotional and behavioral disorders.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1270
Staffing Requirements

(1) ICTS providers must have the clinical leadership and sufficient QMHP, QMHA and other staff to meet the 24-hours, seven days per week treatment needs of children served. The provider must establish policies and practices to assure:

(a) Availability of a LMP to meet the following requirements:

(A) Provide medical oversight of the clinical aspects of care and consult on clinical care;

(B) Prescribe medicine or otherwise assure that case management and consultation services are provided to obtain prescriptions, and prescribe therapeutic modalities to achieve the child's treatment and service coordination goals; and

(C) Participate in the provider's Quality Management process.

(b) An executive director or clinical director who meets the following minimum qualifications:

(A) Masters degree in a human service-related field from an accredited school;

(B) Five years experience in a human services program;

(C) Documented professional references, training and academics; and

(D) Subscribes to a professional code of ethics.

(2) ICTS providers must have adequate numbers of QMHP, QMHA and other staff whose care specialization is consistent with the duties and requirements of the specific level of service intensity. Professional staff must operate within the scope of their training and licensure.

(3) Staffing must be adequate to provide timely response to crises, potential crises, and other urgent and non-urgent child and family service needs 24 hours a day, seven days per week for the clients they serve.

(4) Providers must have adequate numbers of qualified supervisory staff to oversee service delivery in community settings by QMHP, QMHA, and other staff.

(5) Providers must document in personnel files that all supervisory and clinical staff meet all applicable professional licensing and/or certification, and QMHP or QMHA competencies.

(6) Providers must document in personnel files that supervisory and clinical staff are qualified and meet competencies to provide ICTS services as defined by these rules.

(7) Providers must maintain a personnel file for each employee that contains:

(a) The employment application;

(b) Verification of a criminal history check as required by ORS 181.536–181.537;

(c) A written job description;

(d) Documentation and copies of relevant licensure and/or certification that the employee meets applicable professional standards;

(e) Annual performance appraisals;

(f) Annual staff development and training activities;

(g) Employee incident reports;

(h) Disciplinary actions;

(i) Commendations; and

(j) Reference checks.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1275
Behavior Support

Providers must have a written behavior support policy specifying which behavior support practices may be used by the provider, the circumstances under which they may be used, and how the practices will be clinically reviewed. Manual restraint, mechanical restraint, and seclusion may only be used by providers who are certified by OMHAS to use restraint and seclusion as outlined in OAR 309-032-1100 through 309-032-1230. To ensure that providers are administering and documenting well defined responses of planned and therapeutic interventions to specific target behaviors, the provider's behavior support policy must:

(1) Outline behavior support techniques and treatment interventions used in accordance with a process established by care, treatment, and service leaders;

(2) Require that the selection of interventions considers clinical appropriateness and minimizes restrictiveness of interventions;

(3) Specify that a behavior support plan that outlines individualized behavior support techniques and interventions will be developed, implemented, and reviewed for each child. The policy must specify that each child must have thresholds of behavior support interventions that will activate a clinical review. The review must occur when thresholds have been surpassed and at each service coordination plan review;

(4) Establish a framework, which assures that the child, family, and others who comprise the child and family team have involvement with the child's behavior support plan, and that families are educated about and consent to the plan and treatment interventions, and are involved in the monitoring and updating of the plan;

(5) Describe the manner in which staff, paraprofessionals, or others identified in the behavior support plan will be trained to maintain the child's behavior support plan and manage aggressive, assaultive, or other problem behaviors and de-escalate volatile situations through a crisis intervention training program;

(6) Specify behavior support interventions and procedures that are prohibited including:

(a) Procedures that are implemented by another client or unauthorized person;

(b) Procedures that deny basic needs such as diet, water, shelter, or essential clothing; and

(c) Physical punishment or fear-eliciting procedures.

(7) Require that the provider review and update the behavior support policies, procedures, and practices annually; and

(8) Be reviewed and approved by the provider's clinical leaders.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1280
Establishment and Maintenance of Clinical Records

(1) A separate, individualized clinical record must be opened and maintained for each child served by an ICTS provider. If the ICTS provider is also the outpatient or ITS provider or both, the clinical record will include documentation of outpatient, ITS, and ICTS services.

(2) Each clinical record must be uniform in organization, readily identifiable and accessible, and contain all of the components required by this rule in a current and complete manner.

(3) All documentation required in this rule must be signed by the staff providing the service and making the entry. Signature must include the person's academic degree or professional credential and the date signed.

(4) All procedures in this rule requiring consent and the provision of such information to the consenting custodial parent or guardian or where appropriate, the child, must be documented in the clinical record on forms describing what the child or adult giving consent has been informed of, and asked to consent to, and signed and dated by the consenting person. If the provider does not obtain the required documentation, the reasons must be specified in the clinical record and signed by the qualified supervisor of the person responsible for provision of treatment services to the child.

(5) Errors in the clinical record must be corrected by lining out the incorrect data with a single line in ink, and then adding the correct information, the date corrected, and the initials of the person making the correction. Errors in paper or electronic health records may not be corrected by removal or obliteration.

(6) References to other persons being treated by the CMHP, CMHP subcontractors, or other providers when included in the child's clinical record must preserve the confidentiality of the other clients.

(7) Clinical records must be secured, safeguarded, stored, and retained in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(8) All clinical records are confidential to the extent provided for in OAR 309-032-1030(9) and other state and federal laws, rules, or regulations.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1285
Clinical Record Documentation Requirements

The child's clinical record must contain adequate written information that is readily accessible and uniformly placed in the clinical record to include:

(1) Identifying data including the child's name, date of birth, sex, address, phone number, and name of parent(s) or legal guardian including an address and phone number if different;

(2) Level of need determination documentation;

(3) A comprehensive mental health assessment or assessment update to be completed within 14 calendar days from the date the provider receives an authorized request for ICTS services. An assessment update must include the most current information related to all domains of the Comprehensive Mental Health Assessment. Comprehensive mental health assessments and assessment updates are updated annually and reviewed and approved by the LMP;

(4) An individualized treatment plan to be completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The treatment plan is reviewed and revised quarterly and when changes in treatment planning occur and is approved by the LMP;

(5) A service coordination plan to be completed within 30 calendar days from the date the provider receives an authorized request for ICTS services. The plan is reviewed and revised quarterly, and when changes in service coordination planning occur, by the child and family team;

(6) Documentation of child and family team meetings;

(7) Documentation of the services recommended by the child and family team;

(8) Progress notes documenting specific treatments, interventions, and activities related to the implementation of the service coordination plan and the treatment plan;

(9) In addition to OAR 309-032-1285(7), monthly summary progress notes by the care coordinator that document that the child and family team has discussed progress with treatment and service coordination planning and if necessary convened a child and family team meeting to facilitate timely and appropriate service coordination planning;

(10) Written ICTS discharge criteria as documented in the service coordination plan;

(11) A written ICTS discharge summary related to the service coordination plan;

(12) Written discharge criteria as documented in the treatment plan;

(13) A written discharge summary related to the treatment plan; and

(14) A medication service record if medication is prescribed on the treatment plan.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1290
Child & Family Rights

Providers must establish written policies and procedures pertaining to child and family rights. The written statement of rights must be posted prominently in simple, easy to understand language on a form devised by the provider or the OMHAS. Written information must be provided in the non-English languages of the clients served. Information about rights must be available in alternate formats, taking into consideration the special needs of children and families. At the time of admission the provider must give this form to the person legally giving consent to treatment of the child. In addition, these rights must be explained orally at the time of admission to the person giving consent to treatment and to the child, in a manner appropriate to the child's developmental level. Statement of Rights must include the following:

(1) The right to consent to treatment in accordance with ORS 109.640 and 109.675. A custodial parent or legal guardian, or a minor child under conditions described below, must give written informed consent to diagnosis and treatment.

(a) Minor children can give informed consent for outpatient diagnosis and treatment for a mental or emotional disorder in the following circumstances:

(A) Under age 18 and lawfully married.

(B) Age 14 or older.

(b) If the child is initially served in a crisis situation, these rights must be explained as soon as clinically practical, but not more than five working days from the initiation of services if the child who received the crisis service remains in service.

(c) The custodial parent or legal guardian of any minor, age 14 or older who has consented to outpatient treatment or diagnosis, must be involved before the end of treatment unless:

(A) The parents refuse;

(B) There are clear clinical indications to the contrary;

(C) The child has been sexually abused by the parent; or

(D) The child has been legally emancipated by the court, or has been self sustaining for 90 days prior to obtaining treatment. As required in ORS 109.675, such refusal or the reasons for exclusion must be documented in the child's clinical record.

(2) The right to refuse services. The person giving consent to treatment has the right to refuse service, including any specific treatment procedure. If serious consequences may result from refusing a service, the provider must explain the consequences verbally or in writing to the custodial parent, the guardian, or the child who is refusing service. Service refusal must be documented in the clinical record.

(3) The right to confidentiality in accordance with ORS 179.505, 107.154, 418.312, and any other applicable state and federal regulation.

(4) The right to consent to disclosure of clinical records. The person consenting to treatment, usually the custodial parent or guardian, has the right to authorize disclosure of the child's clinical record in accordance with ORS 179.505 and any other applicable state and federal regulation.

(5) The right to immediate inspection of the clinical record unless access is restricted in accordance with ORS 179.505.

(a) The child, if able, and the custodial parent(s) or guardian of a minor child has the right to immediate inspection of the record.

(b) A copy of the record is to be provided within five working days of a request for it. The person requesting the record is responsible for payment for the cost of duplication, after the first copy.

(c) Identifying and clinical information about the child must be protected in provider publications such as newsletters and brochures.

(6) The right to participate in treatment planning and service coordination. The child, if appropriate, and the custodial parent(s) or legal guardian and others of their choosing, must have the opportunity to participate in an informed way in the treatment planning and service coordination process for the child, and in the review, at least every three months, of the child's progress toward treatment goals and objectives. At a minimum, the following information should be discussed:

(a) Treatment and other interventions to be undertaken;

(b) Alternative treatments or interventions available, if any;

(c) Projected time to complete the treatment process;

(d) Benefits which can reasonably be expected; and

(e) Risks that may be involved in treatment, if any.

(7) The right to make informed consent to fees for services. The amount and payment schedule of any fees to be charged must be disclosed in writing and agreed to by the person consenting to treatment.

(8) The rights contained in this section may be asserted and exercised by the child (except where the law requires that only the parent or guardian may exercise a particular right), the child's parent or guardian, or any representative of the child.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1295
Quality Management

Providers must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to children and families. Rules related to Quality Management and Quality Assurance as set forth in OAR 309-032-1060 are applicable to ICTS providers who are certified as providers of Community Mental Health Treatment Services for Children. Rules related to Quality Management and Quality Assurance as set forth in OAR 309-032-1295 are applicable to ICTS providers who are certified as providers of Children's Intensive Mental Health Treatment Services and providers of both Children's Intensive Mental Health Treatment Services and Community Mental Health Treatment Services for Children. Providers will implement a Quality Assurance system, which will assure compliance with the provisions of OAR 309-032-1240 through 309-032-1305.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1300
Grievances and Complaints

Rules related to grievances, complaints, service denials, appeals, and hearing requests as set forth in OAR 309-032-1030(4)–(6) are applicable to ICTS providers who are certified as providers of Community Mental Health Treatment Services for Children. Rules related to complaints, service denials, appeals, and hearing requests as set forth in OAR 309-032-1210 are applicable to ICTS providers who are certified as providers of Children's Intensive Mental Health Treatment Services and providers of both Children's Intensive Mental Health Treatment Services and Community Mental Health Treatment Services for Children.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

309-032-1305
Variance

A variance from portions of these rules that are not derived from federal regulations or the Office of Medical Assistance Program (OMAP) General Rules may be granted for a period of up to one year or a time period specified on the provider's Certificate of Approval in the following manner:

(1) The provider must submit a written request to the Assistant Administrator of OMHAS, which includes:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed; and

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(2) The Assistant Administrator of OMHAS must approve or deny the request for variance in writing.

(3) OMHAS will notify the provider of the decision in writing within 30 days of the receipt of the request.

(4) Appeal of the denial of a variance request must be to the Administrator of OMHAS whose decision will be final.

(5) All variances must be reapplied for as directed by OMHAS.

Stat. Auth.: ORS 430.640 & 743.556
Stats. Implemented: ORS 430.630
Hist.: MHD 1-2005(Temp), f. & cert. ef. 1-3-05 thru 7-1-05; MHD 6-2005, f. 6-24-05, cert. ef. 7-1-05

DIVISION 33

INVOLUNTARY COMMITMENT PROCEEDINGS

General Standards for Civil Commitment

309-033-0200
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe general standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.060, 426.072(3), 426.075, 426.110(2), 426.120, 426.140(2), 426.170, 426.180, 426.217, 426.220, 426.225, 426.228, 426.231, 426.232, 426.233, 426.236, 426.241(5), 426.495, 426.500, 430.041, 430.205 through 430.210 and carry out the provisions of ORS 426.005 through 426.309. These rules replace OAR 309-033-0100 though 309-033-0170, which were in effect from September 2, 1992 through August 31, 1994.

Stat. Auth.: ORS 426.005 - 426.309
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0000

309-033-0210
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assignment" means the designation, pursuant to ORS 426.060, by the Division or its designee of the hospital, facility or CMHP where the committed person is to receive care, custody and treatment during the commitment period.

(3) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(4) "Caregiver" means the person who is appointed by the court under ORS 426.125 to be allowed to care for a mentally ill person on conditional release.

(5) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(6) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(7) "Community hospital" means any hospital that is not a state hospital.

(8) "County governing body" means the county court or the board of county commissioners of one or more counties who operate a CMHP, or in the case of a Native American Reservation, the Tribal Council, or if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation selected by the county.

(9) "County of residence" means the county where the person currently maintains a mailing address or, if the person has no current mailing address within the state, the county where the person was found or the county in which a committed person has been conditionally released as defined by ORS 426.241(4).

(10) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(11) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(12) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(13) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(14) "Director of the county of commitment" means the director for the county where the person is committed.

(15) "Director of the county of placement" means the director for the county where the committed person is to be placed.

(16) "Director of the county of residence" means the director for the county of residence.

(17) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(18) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(19) "Hospital hold" means the taking of a person into custody by order of a physician pursuant to ORS 426.232.

(20) "NMI" is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and

426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(21) "Nonhospital hold" means the taking of a person into custody by order of a director pursuant to the provisions of ORS 426.233. A director's hold and a trial visit hold are variations of a nonhospital hold.

(22) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(23) "Placement of a committed person" means the physical act of removing a committed person from the courtroom to the place where the person has been assigned to receive care, custody and treatment, or the transfer of a committed person from one location where the person has been assigned to receive care, custody and treatment to another location for the same purpose.

(24) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(25) "Psychologist" means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

(26) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(27) "Recertification" means the certification of continued commitment provided for under ORS 426.301.

(28) "Secure transport provider" means a secure transport provider approved according to OAR 309-033-0440, Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or on Diversion to an Approved Holding or Nonhospital Facility.

(29) "State hospital" means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(30) "Superintendent" means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0010; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0220
General Standards

(1) Goals. The goals of the Division in implementing these civil commitment standards are:

(a) To promote the well-being of persons who are allegedly mentally ill and who are mentally ill during involuntary care, custody and treatment of mental illness pursuant to ORS Chapter 426;

(b) To promote the protection of the civil rights of each person who is allegedly mentally ill and who is mentally ill;

(c) To encourage consistent application of ORS Chapter 426 as it specifically pertains to each of the following groups:

(A) Persons who are alleged to be mentally ill; and

(B) Persons who are mentally ill.

(d) To encourage the provision of care, custody and treatment of persons in the least restrictive environment that currently is available within existing resources;

(e) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through civil commitment, whenever possible;

(f) To encourage that the director monitors the commitment process in their county, is knowledgeable of the statutes and administrative rules pertaining to civil commitment, provides leadership so that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS Chapter 426;

(g) To provide for the safety of the community when threatened by a person who is dangerous as a result of mental illness.

(2) State's interest. The state's interest is to establish sufficient facts for the court to make a decision that is consistent with the intent of ORS Chapter 426.

(3) Declaration for mental health treatment. The director shall establish procedure and policy which assures that every person who may become incapacitated by mental illness and unable to consent to treatment is educated about the Declaration for Mental Health Treatment at the time of admission or at the time of discharge from a hospital.

Stat. Auth.: ORS 426.060
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0030

309-033-0230
Custody of Persons Alleged to Be Mentally Ill Prior to Filing a Notification of Mental Illness

(1) Custody by a physician pursuant to ORS 426.231. A physician taking a person into custody pursuant to ORS 426.231 at a hospital approved under OAR 309-033-0550, Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility, shall detain the person for no more than 12 hours and during that time shall either:

(a) Authorize the person for transportation to an approved hospital and provide transportation according to the agreement required under OAR 309-033-0550; or

(b) Release the person, if the physician determines that the person no longer is dangerous to self or others.

(2) Custody by a peace officer or secure transport provider. A peace officer taking a person into custody shall remove the person to an approved hospital as directed by the director in the county where the person was taken into custody. The peace officer or approved secure transport provider shall only take a person into custody under the provisions of one of the following:

(a) Custody on peace officer's own initiative. A peace officer may take a person into custody pursuant to the provisions of ORS 426.228 when the peace officer has probable cause to believe that the person is dangerous to self or others, and is in need of immediate care, custody or treatment for a mental illness;

(b) Custody on the director's authority. The director may direct, pursuant to the provisions of ORS 426.233(1), a peace officer or an approved secure transport provider to take into custody a person who is dangerous to self or others and in need of immediate care, custody or treatment for mental illness;

(c) Custody of a committed person on the director's authority. The director may direct a peace officer or an approved secure transport provider to take into custody, pursuant to the provisions of ORS 426.233(1), a committed person who is on trial visit, outpatient commitment or conditional release in the community, who is dangerous to self or others or who is unable to provide for basic personal needs, who is not receiving the care that is necessary for health and safety, and who is in need of immediate care, custody or treatment for mental illness.

(d) A peace officer may transfer a person in custody under this section to the custody of an approved secure transport provider. The peace officer may meet the approved Secure transport provider at any location that is in accordance with ORS 426.140 to effect the transfer. When transferring a person in custody to an authorized person, the peace officer shall deliver the report required under subsection (3) of this section to the authorized person.

(3) Peace officer's written report. When taking a person into custody pursuant to ORS Chapter 426.228(1) by a peace officer's own initiative, a peace officer shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(4) Director's written report. When a peace officer or approved secure transport provider takes a person into custody pursuant to ORS Chapter 426.228(4) at the direction of the director, a director shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(5) Transportation to a hospital or nonhospital facility more than one hour away. If the peace officer determines that more than one hour is required to transport the person to a hospital or nonhospital facility approved by the Division, the peace officer or approved secure transport provider shall obtain a certificate, if possible, from a physician prior to transporting the person. A physician authorizing transport shall sign a certificate, on a form approved by the Division, only if the person's condition, in the opinion of the physician, meets all of the following requirements:

(a) The travel will not be detrimental to the person's physical health;

(b) The person is dangerous to self or others; and

(c) The person is in need of immediate care or treatment for mental illness.

(6) The director directs peace officers or approved secure transport providers to appropriate facility. The director shall adopt written procedures for directing peace officers or approved secure transport providers to transport persons taken into custody, pursuant to ORS 426.228, to an approved hospital or nonhospital facility:

(a) The written procedures shall include one of the following, whichever, in the opinion of the director, serves the best interests of persons with mental illness and the community:

(A) A list of approved hospitals or nonhospital facilities where peace officers or approved secure transport providers are to transport persons;

(B) A procedure for contacting the director 24 hours-a-day, seven days-a-week.

(b) The director shall distribute copies of the written procedures to the sheriff and the chief of police of each municipality in the county and approved secure transport providers. The procedures shall be distributed as often as the procedure is amended.

(c) The director may develop a written agreement with the law enforcement agencies in the county which designates a site or sites where the director can safely evaluate the person and determine which facility, in the director's opinion, can best serve the person's needs within the resources available. If such an agreement exists in a county, the director may direct a peace officer to transport a person in custody under ORS 426.228 to a site designated in the agreement. Once the director makes a determination, the peace officer shall transport and deliver the person to a hospital or nonhospital facility as directed by the director. The agreement shall:

(A) Designate the site or sites where the director can safely evaluate the person's needs for treatment;

(B) Define the minimum response time for the director meeting the peace officer at the site; and

(C) Be signed by all parties to the agreement.

Stat. Auth.: ORS 426.228, 426.231 & 426.236
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0040; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0240
Initiation of the Civil Commitment Process

(1) Initiation. The civil commitment process is initiated when an NMI is filed with the circuit court. The NMI shall be filed with the court as directed below:

(a) Public petition. When an NMI is given to the director of the county where the allegedly mentally ill person resides pursuant to ORS 426.070, the director shall immediately file the NMI with the court in the county where the allegedly mentally ill person resides. The following persons may give an NMI to the director:

(A) Any two persons;

(B) A county health officer; or

(C) Any magistrate.

(b) Hospital hold with no request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, Hospital Hold, and the director in the county where the person resides makes no request for the physician to file the NMI in the county where the person resides, the physician shall file the NMI with the court in the county where the person is hospitalized;

(c) Hospital hold with request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, and the director in the county where the person resides requests the physician to do so, the physician shall file the NMI with the court in the county where the person resides;

(d) Hospital hold subsequent to peace officer custody with no request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located makes no request, pursuant to ORS 426.234(2)(b), the physician shall file the NMI with the court in the county where the person initially was taken into custody by the peace officer;

(e) Hospital hold subsequent to peace officer custody with request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located requests the physician to do so, the physician shall file the NMI with the court in the county where the person is hospitalized.

(f) Nonhospital hold with no request from director. When a director in the county where the director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides makes no request for the director to file the NMI be filed in the county where the person resides, the director shall file the NMI with the court in the county where the person initially was taken into custody; and

(g) Nonhospital hold with request from director. When a director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides requests the director to do so, the director shall file the NMI with the court in the county where the person resides.

(2) Initiation of commitment proceedings by two persons, a county health officer or magistrate. The NMI shall be given to the director in the county where the allegedly mentally ill person resides. If the person has no residence, then the NMI shall be given to the director in the county where the person currently is located. The director shall file the original NMI with the court on the day the NMI is received or, if the NMI is received outside the court's routine business hours, the next day the court is open for business. The director shall retain a copy of the NMI in the clinical record as required by OAR 309-033-0930(2)(f), Procedures for the Investigation.

(3) Initiation by hospital hold. The physician who takes a person into custody, pursuant to ORS 426.232, in a hospital approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, shall:

(a) File an NMI with the appropriate court as described in OAR 309-033-0240(1), Initiation; and

(b) Immediately notify the director in the county in which the person was hospitalized, unless the person resides in a county other than the county where the person is hospitalized in which case the physician shall immediately notify the director in the county where the person resides.

(4) Initiation by nonhospital hold. The director, after authorizing the taking of a person into custody pursuant to the provisions of ORS 426.233 (the director's hold and trial visit hold), shall file a NMI with the appropriate court as described in OAR 309-033-0240(1).

(5) How a director requests where the NMI is filed. A director may request that the physician, in the case of a hospital hold, or the director of the county where the person was taken into custody, in the case of a nonhospital hold, file the NMI according to the provisions of ORS 426.234 by either:

(a) On a case by case basis. Making the request immediately upon receipt of the notice required by ORS 426.234(2)(a) or (b), or 426.234(3)(a); or

(b) Upon general request. Sending a written general request to a hospital or a director.

Stat. Auth.: ORS 426.070, 426.232, 426.234 & 426.236
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0050; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0250
Standards for Custody, Hospital and Nonhospital Holds, Emergency Commitment and Emergency Hospitalization of Persons Under Warrant of Detention

(1) Criteria for placement into custody. Only persons who are a danger to self or others and who are in need of treatment for mental illness shall be placed in custody at a facility approved by the Division.

(2) Warrant of detention. Upon the receipt of a warrant of detention issued by the court pursuant to ORS 426.070(5)(b), the director or the sheriff of the county shall take the person into custody and remove the person to a hospital approved by the Division. Whoever takes the person into custody shall inform the person of his/her rights with regard to representation by or appointment of counsel as described in ORS 426.100 and be given the warning described under ORS 426.123 and OAR 309-033-0540(2)(a), Warning.

(3) Hospital hold. Only a physician with admitting privileges or on staff at a hospital approved by the Division and who has completed a face-to-face examination of the person may retain the person in custody in the hospital as provided by ORS 426.232. When implementing hospital holds, the hospital shall assure the following:

(a) The consulting physician is not required to have admitting privileges at the hospital;

(b) The hospital shall not require the consulting QMHP to be a member of the hospital's allied staff. However, the hospital may extend allied staff privileges to the consulting QMHP;

(c) The admitting physician shall document the following information on the NMI, retaining a copy of the NMI in the clinical record:

(A) Examples of indicators that support the physician's belief that the person has a mental illness;

(B) Examples of thoughts, plans, means, actions, history of dangerousness or other indicators that support the physician's belief that the person is imminently dangerous.

(4) Peace officer custody requested by director. This section establishes standards and procedures for a director to direct a peace officer to take into custody a person who the director has probable cause to believe is dangerous to self or any other person and who the director has probable cause to believe is in need of immediate care, custody or treatment for mental illness:

(a) A county governing body may authorize the director, or a person named and recommended by the director, to direct a peace officer or approved secure transport provider to take allegedly mentally ill persons into custody. Such an authorization shall be made formally and in writing by the county governing body of the director. The director shall keep a copy of each authorization in each person's personnel file:

(b) Prior to directing a peace officer or approved secure transport provider to take a person into custody, a director shall have face-to-face contact with the person and document on forms approved by the Division, the evidence for probable cause to believe that the person is:

(A) Dangerous to self or others; and

(B) In need of immediate care, custody or treatment for a mental illness.

(5) When a person in custody can be released. A person shall who is detained, in custody, or on a hold shall be released as described:

(a) Physician's release of a person on peace officer custody. When a person is brought to a hospital by a peace officer or approved secure transport provider pursuant to ORS 426.228, Peace Officer Custody, the treating physician shall release the person if, upon initial examination prior to admission, the physician makes the determination that the person is not dangerous to self or others. It is not necessary to notify the court of the release;

(b) Physician's release of a person on transport custody. At any time during the 12 hour detention period, the treating physician shall release a person detained pursuant to ORS 426.231, Transport Custody, whenever the physician makes the determination that the person is not dangerous to self or others. In no case shall a physician involuntarily detain a person at a hospital approved solely for Transport Custody under OAR 309-033-0550 longer than 12 hours. It is not necessary to notify the court of the release;

(c) Physician's release of a person on a hospital hold. The treating physician shall release a person retained or admitted to a hospital pursuant to ORS 426.232, Hospital Hold, whenever the physician makes the determination that the person is not dangerous to self or others. The treating physician shall immediately notify the director and the circuit court where the NMI was filed. See OAR 309-033-0240; or

(d) Director's release of a person on a nonhospital hold. The director shall release a person detained in a nonhospital facility, approved under OAR 309-033-0530, pursuant to ORS 426.233, Nonhospital Hold, whenever the director, in consultation with a physician, makes the determination that the person is not dangerous to self or others. The director shall immediately notify the circuit court.

(6) When a person in custody cannot be released. Once the person is admitted to a hospital or nonhospital facility, a person taken into custody pursuant to ORS 426.070 (warrant of detention), may only be released by the court. However, a person may be discharged from a hospital or nonhospital facility when the person is transferred to another approved facility.

Stat. Auth.: ORS 426.070, 426.231, 426.232, 426.233, 426.234 & 426.228
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0060; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0260
Diversion from Commitment Hearing

(1) Notice to court by director. The director and a psychiatrist may certify a person for diversion at any time up to three judicial days after the person has been taken into custody.

(2) Treatment plan. The director and the treating psychiatrist shall prepare a treatment plan that describes, in general terms, the types of treatment and medication to be provided during the diversion. The general treatment plan shall be descriptive of the range of services and medications to be provided, and shall include a description of:

(a) Any of the following classes of medication, if medication is to be administered:

(A) Antipsychotics;

(B) Antidepressants;

(C) Mood stabilizers;

(D) Anti-anxiety medications; or

(E) Anti-side effect medications.

(b) Mental health interventions, therapies or diagnostic procedures to be employed;

(c) The person's preferences about medications and therapies and any limitations on the specific use of medications or therapies to which the director and the treating psychiatrist have agreed;

(d) Location where treatment is to be initiated and the type of hospital or nonhospital facilities where the person may be transferred during the diversion; or

(e) Other conditions or limitations agreed to by the person and the director concerning the care or treatment that is to be provided.

(3) Notice to person. At the initiation of the diversion period, the director and the psychiatrist shall inform the person verbally, and in writing, of the usual and typical restraints or seclusion which may be employed in an emergency to assure health or safety.

(4) Psychiatrist to provide information. The psychiatrist shall provide the information described in OAR 309-033-0620(5)(a), Procedures for Obtaining Informed Consent and Information to be Given, when administering a specific medication.

(5) Consent for non-psychiatric care. A treating physician shall obtain the person's consent for non-psychiatric medical care and treatments which may be prescribed during the diversion. The general treatment plan for psychiatric intervention shall not include plans for non-psychiatric medical care or treatment.

(6) Refusal of treatment/demand for discharge. The person on diversion may refuse psychiatric treatment described in the general treatment plan or demand discharge at any time during the diversion by signing the form described in this paragraph or, if the person refuses to sign the form, by verbally making his or her refusal of treatment or demand for discharge known to two staff of the facility. In accepting the person's refusal of treatment or demand for discharge the staff of the facility shall:

(a) Provide the person a warning, both verbally and in writing, at the person's first indication that he/she wishes to refuse treatment or demand discharge, which states:

"If you refuse psychiatric treatment described in the general treatment plan or demand to be discharged you may be required to appear at an involuntary civil commitment hearing. It is your right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. However, if a judge finds you not to be a mentally ill person you may be released. The treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy

of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing."

(b) If the person refuses treatment, demands discharge or requests a hearing, offer the person the following form to sign:

"Warning

If you refuse psychiatric treatment described in your general treatment plan or demand discharge you may be required to appear at an involuntary civil commitment hearing. You have a right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. The psychiatric treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing.

I refuse the treatment described in my general treatment plan.

I request a hearing before the circuit court.

_____

Signature of Certified Person."

(c) If the person refuses to sign the form described in this section and verbally or nonverbally refuses treatment, the staff of the facility shall document the person's refusal on the form and in the person's clinical record;

(d) Immediately upon the person's refusal of treatment, demand for discharge or request for a hearing, the treating physician shall treat the person as a person in custody, as provided under ORS 426.072, and shall immediately notify the director. The director shall immediately request a hearing.

(7) Director of the county of residence approval of payment for diversion. A person shall be on diversion only if payment for the care, custody and treatment is approved verbally by the director of the county of residence as provided under ORS 426.237(1)(b)(B). The director of the county of residence's approval shall be documented by a written statement, signed by the director, and distributed by the end of the diversion period as follows:

(a) The original shall be filed in the clinical record at the CMHP; and

(b) A copy shall be delivered to each facility serving the person during the diversion.

Stat. Auth.: ORS 426.236 & 426.237
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0070

309-033-0270
Provision of Care, Custody and Treatment of Persons Committed to the Division

(1) Provision of rights. In addition to the rights provided under ORS 426.385, committed persons also have the rights provided under ORS 430.205 through 430.210.

(2) Provision of care at a state hospital. The superintendent of the state hospital serving the county of commitment shall be responsible for all admissions to the state hospital:

(a) The superintendent, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to the state hospital;

(b) The superintendent shall implement policies and procedures which afford a committed person placed in a state hospital the rights provided by ORS 426.385 and 430.205 through 430.210.

(3) Provision of care at a community hospital. The director shall assign and place a committed person only at a community hospital approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion:

(a) The admitting physician, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a community hospital;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a community hospital the rights provided by ORS 426.385 and 430.205 through 430.210.

(4) Provision of care at a nonhospital facility or an outpatient program. The director shall only assign and place a committed person in a nonhospital facility that is licensed or certified by the Division:

(a) The administrator, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a nonhospital facility or an outpatient program;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a nonhospital facility or an outpatient program the rights provided by ORS 426.385 and 430.205 through 430.210;

(c) The director shall place on a trial visit a committed person who is discharged from a state hospital or a community hospital when the director assigns and places the person in a nonhospital facility;

(d) The director shall place a committed person, who the court has ordered on outpatient commitment at the commitment hearing, on outpatient commitment when the director assigns and places the person in a nonhospital facility.

(5) Provision of medical services for a committed person. The superintendent of a state hospital, the treating physician at a community hospital or the director may transfer a committed person to a general hospital, or transfer a committed person from a psychiatric ward to a medical ward for medical care:

(a) The treating physician shall only provide medical care with the consent of the committed person in accordance with OAR 309-033-0600 through 309-033-0650, Standards for Obtaining Informed Consent to Treatment From a Person and the Administration of Significant Procedures Without the Informed Consent of a Committed Person at Community Hospitals, Nonhospital Facilities, and Residential Facilities Approved by the Division;

(b) The superintendent or treating physician shall transfer a committed person to a general hospital for medical services on a pass or discharge the person from the state hospital when it is determined that the person will not return to the state hospital within a reasonable length of time, or that discharge is clinically appropriate and is required for the person to have access to third-party insurance benefits;

(c) The treating physician shall immediately notify the director that a person was transferred to another hospital for medical care under this subsection.

Stat. Auth.: ORS 426.060, 426.385 & 430.205 - 430.210
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0080

309-033-0280
Procedures for Committed Persons on Outpatient Commitment or Trial Visit

(1) Outpatient commitment. At the time of the commitment hearing the director may place a committed person on an outpatient commitment if adequate treatment services are available in the county. The director shall be responsible for:

(a) Enrolling the committed person in treatment services and assuring that the committed person has an opportunity to participate in the development of the treatment plan;

(b) Distributing the conditions of placement as pursuant to ORS 426.278 and OAR 309-033-0280(3), Distribution of the Conditions of Placement, below;

(c) Monitoring and documenting the provision and consumption of services which fulfill the conditions set for the outpatient commitment;

(d) Petitioning the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(e) With the participation of the committed person, changing the conditions to less restrictive conditions, if appropriate; and

(f) Documenting in the clinical record any conditions of placement requiring modification by means of a report which:

(A) Documents the need for a change in the conditions of outpatient commitment;

(B) Sets new conditions of commitment;

(C) Describes the reasons for the new conditions;

(D) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the report; and

(E) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons described in OAR 309-033-0280(3), Distribution of the Conditions of Placement, below.

(2) Trial visit. The director may grant a trial visit to any committed person during a period of commitment, upon approval of the director of the county of placement. A director may grant a trial visit to any committed person during a period of community inpatient treatment. While it may be clinically advisable, the director is not required to obtain the consent or signature of the committed person:

(a) Trial visit of a committed person shall not exceed the time remaining in the period of commitment;

(b) Conditions for trial visit shall include designation of a facility, service or other provider to provide care or treatment;

(c) The director shall place the person on trial visit in accordance with OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division;

(d) The director shall evaluate any complaints received from any person concerning the behavior or treatment of a committed person on trial visit. The director shall document the results of the evaluation in the clinical record;

(e) Modification of the conditions of trial visit. The director may modify the conditions of placement for trial visit:

(A) Any modification shall not include a treatment option which is more restrictive than the current conditions of placement;

(B) The director shall petition the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(C) The director shall document in the clinical record any conditions of placement requiring modification by means of a report which:

(i) Documents the need for a change in the conditions of outpatient commitment;

(ii) Sets new conditions of commitment;

(iii) Describes the reasons for the new conditions;

(iv) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the clinical record; and

(v) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons provided under ORS 426.278 and OAR 309-033-0280(3), Distribution of the Conditions of Placement, below.

(f) Transfer of trial visit to another county. The director may transfer a person on trial visit to another county only if the director for the county where the person will reside agrees to accept the trial visit:

(A) The director of the county where the person currently resides shall provide the director of the county where the person will reside a copy of the current treatment plan for the person on trial visit;

(B) Immediately upon accepting the trial visit the director of the county where the person will reside shall enroll the person on trial visit in treatment services and shall make any modifications in the trial visit as necessary and distribute the modified conditions of placement as required under OAR 309-033-0280(3), Distribution of the Conditions of Placement, below.

(3) Distribution of the conditions of placement. When a committed person is placed on conditional release, outpatient commitment or trial visit, or when the conditions of placement are modified in any manner, the current conditions of placement shall be distributed by the director to the following persons, pursuant to ORS 426.278:

(a) The committed person;

(b) The director of the county in which the committed person is to receive hospital, nonhospital or outpatient treatment;

(c) The administrator of any facility, service or other provider designated to provide care or treatment;

(d) The court of current commitment; and

(e) The appropriate court of the county in which the committed person lives during the commitment period if the person is living in a different county than the county of the court that made the current commitment.

Stat. Auth.: ORS 426.127, 426.273 & 426.278
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0090

309-033-0290
Assignment and Placement of Persons Committed to the Division

(1) Assignment authority. The Division, pursuant to ORS 426.060(2)(d), delegates the responsibility for the assignment and placement of committed persons to the director of the county of commitment:

(a) The director may assign or transfer a committed person to any facility or program approved by the Division which, in the opinion of the director, will appropriately meet the mental health needs of the committed person;

(b) The director may discharge the committed person from commitment by notifying, in writing, the court having jurisdiction, if the director determines the person no longer is a mentally ill person as defined by ORS 426.005(2).

(2) Assignment outside the county of residence. The director of the county of commitment may assign the committed person to a facility in a county other than the county of residence only with the approval of the director of the county of residence and the director of the county of placement:

(a) When the director of the county of commitment assigns a committed person under this section, the director of the county of commitment shall transfer the responsibility for assignment and placement to the director of the county of placement;

(b) The Assistant Administrator shall assign a committed person under this section when the director of the county of commitment, the director of the county of residence and the director of the county of placement determine that they cannot agree on the assignment of the person and request the Division to make the assignment:

(A) The Assistant Administrator shall determine fiscal responsibility for the services to be delivered to the committed person and shall look to existing applicable laws, contracts and interagency agreements;

(B) The decision of the Assistant Administrator shall be final.

(c) When placement is determined, the director of the county of placement shall accept the responsibility for further assignment and placement;

(d) The director of the county of commitment shall petition the court in the county where the person was committed to transfer jurisdiction to the court in the county where the person is to reside, pursuant to ORS 426.275(5).

(3) Assignment to a state hospital. The director of the county of commitment shall only assign and place a committed person in a state hospital with the consent of the superintendent.

(4) Assignment procedure. The director of the county of commitment shall make the assignment in writing immediately upon commitment of a person by the court or at the time the placement of a committed person is changed during the commitment period. The director shall:

(a) Retain an original assignment order on file in safe keeping for seven years;

(b) Deliver a signed original copy of the assignment order to the person prior to placement;

(c) Enter into the Division's current computer data system information about the committed person including:

(A) Name and any known aliases;

(B) Date of birth;

(C) Address of current residence;

(D) Address where assigned for treatment if different from residence;

(E) Name and telephone number of the administrator of the hospital, facility or program responsible for the person's treatment; and

(F) Any other data as requested by the Division.

(d) Out of county assignments shall include a statement that assignment and placement responsibility is transferred to the director of the county of placement.

(5) Appeal of assignment procedure. At any time during the period of commitment, a committed person may appeal to the Assistant Administrator for Mental Health for a change in assignment made by a director.

(a) How to make an appeal. The committed person shall make the appeal in writing and shall include the following information in the appeal:

(A) A statement that the committed person appeals the current assignment;

(B) The reason(s) the committed person believes the current assignment is inappropriate; and

(C) The proposed alternate placement and the reasons the committed person is requesting the alternate placement.

(b) Appeal of an assignment to a community hospital or to the community. The Assistant Administrator shall make a determination of an appealed assignment for persons currently assigned to community hospitals or community placements. The Assistant Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within

five business days of the receipt of the written appeal. The Assistant Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment; and

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case.

(B) The Assistant Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

(c) Appeal of an assignment to a state hospital. The Administrator shall make a determination of an appealed assignment for persons currently assigned to a state hospital or where the appeal requests assignment to a state hospital. The Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Administrator shall consider the opinion of the superintendent, or designee, of the state hospital affected by the appeal, and the report of the Assistant Administrator. In making the report to the Administrator, the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment;

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case;

(vi) Shall make a recommendation about the proposed assignment; and

(vii) Shall submit the report within three business days after the Division receives the appeal.

(B) The Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

Stat. Auth.: ORS 426.060
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0100

309-033-0300
Transfers Between Classes of Facilities

(1) Transfers between classes of facilities. The director may transfer a committed person from one class of facility to another in the same class or in a less restrictive class as provided by ORS 426.060. However, the director shall transfer a committed person who has voluntarily agreed to placement at the facility only with the written consent of the person. The director shall transfer committed persons as provided by OAR 309-033-0400 through 309-033-0420, Standards for Transportation and Transfer of Persons in Custody or on Diversion, and OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division. The director shall modify the conditions of trial visit to reflect the change of placement and shall notify the following persons of the transfer:

(a) The committed person;

(b) The court in the county where the person was committed;

(c) The court in the county where the person is to be placed;

(d) The director in the county where the person is to reside;

(e) The administrator of the facility designated to provide care or treatment; and

(f) Any other provider designated to provide care or treatment.

(2) Transfers restricted by rule. The director may transfer a committed person from a facility of one class to another facility of a same class or lower class by:

(a) Assigning the committed person to the new facility; and

(b) Modifying the person's commitment status as follows:

(A) Persons transferred to a Class 2 or Class 3 facility. When the director transfers a committed person to a Class 2 or Class 3 facility, the director shall place the person on trial visit (see OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division);

(B) Transfers between Class 1 hospitals or facilities. The director shall transfer a person between Class 1 hospitals or facilities without placing the committed person on trial visit; or

(C) Transfer to any facility and discharged from commitment. When the director determines a committed person is no longer a mentally ill person, the director shall discharge the person from commitment (see OAR 309-033-0330, Discharge of Committed Persons from Commitment Status) and enroll the person in services voluntarily at the receiving facility.

(3) Transfers from a facility of one class to a facility of a more restrictive class:

(a) Involuntary transfers of committed persons. The director shall transfer a committed person, who is on trial visit, to a facility of a more restrictive class only:

(A) By order of the court after a hearing, pursuant to ORS 426.275; or

(B) Initiate involuntary procedures as provided in this paragraph and as provided by ORS 426.233(1) (see subparagraph (c) of this paragraph).

(b) Voluntary transfers of committed persons. The director may transfer a committed person, who is on trial visit, to a facility of a more restrictive class with the committed person's consent. However, if the committed person revokes his/her consent to the current more restrictive placement and requests to be placed at another facility of a less restrictive class, as soon as reasonably possible the director shall:

(A) Transfer the person to a facility where the person consents to receive services; or

(B) Initiate involuntary procedures as provided in this paragraph and by ORS 426.233(1).

(c) Emergency transfers of committed persons. As provided by ORS 426.233(1), the director may transfer a committed person, who is on trial visit, to a hospital or nonhospital facility approved by the Division when the director has probable cause to believe the person is dangerous to self or others or unable to provide for basic personal needs and is not receiving the care that is necessary for health and safety, and is in need of care, custody or treatment for mental illness. Upon the recommendation of the investigator, the director shall request the court to revoke the person's trial visit or recertify the person for continued commitment at a more restrictive facility as provided by ORS 426.275.

(4) Authority to retake persons. A Class 1 or Class 2 facility shall immediately notify a peace officer and the Division of any person who has left the facility without lawful authority and shall immediately request the assistance of a peace officer(s) in retaking and returning the person to a Division-approved hospital or facility. The director shall show the peace officer a copy of the order of commitment.

Stat. Auth.: ORS 426.060, 426.223, 426.233, 426.273, 426.275 & 426.278
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0110

309-033-0310
Recertification for Continued Commitment

(1) Recertification for continued commitment of persons placed in a state hospital:

(a) After consulting with the director of the person's county of residence, the superintendent shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director.

(b) The superintendent shall notify the court concerning:

(A) The date the recertification was issued to the person; and

(B) Whether the person protests, within 14 days of the issuance of the recertification, to continued commitment.

(2) Recertification for continued commitment of persons placed in a community hospital or nonhospital facility:

(a) After consulting with the director of the person's county of residence, the director shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director of the person's county of residence.

(b) The director shall notify the court concerning:

(A) The date recertification was issued to the person; and

(B) Whether the person protests continued commitment, within 14 days of the issuance of the recertification.

(3) Documentation of recertification for continued commitment in the clinical record. The director or the superintendent making the recertification shall include in the clinical record:

(a) The date and time the director's approval of continued commitment was obtained prior to the recertification being issued to the person;

(b) The date and time the recertification was issued to the persons;

(c) A copy of the recertification issued to the person;

(d) Concerning the notification to the court of the date the recertification was issued to the person:

(A) The date and time that the court was notified of the issuance of the recertification to the person; and

(B) A copy of the notification.

(e) Concerning the notification to the court of whether the person protests continued commitment, within 14 days of the issuance of the recertification:

(A) The date and time that the court was notified of whether the person protests; and

(B) A copy of the notification to the court whether the person protests.

(f) If an examination is requested by the person:

(A) The name of the psychiatrist or the certified mental health examiner ordered by the court to conduct the examination;

(B) The date that the examination was conducted; and

(C) A copy of the examination report sent to the court.

(g) If the court orders continued commitment, a copy of the order continuing the commitment; and

(h) If the court orders the release of the person:

(A) A copy of the order requiring release;

(B) If the person consents to services upon discharge, a copy of an aftercare plan signed by the person and the name of the case manager responsible for arranging outpatient services; or

(C) If the person refuses services upon discharge, a statement signed by the person indicating the person's refusal of outpatient services; and

(D) The date and time the person was released from the facility.

Stat. Auth.: ORS 426.301, 426.307 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0120

309-033-0320
Revocation of Conditional Release, Outpatient Commitment or Trial Visit

(1) Conditional release. A caregiver appointed by the court to care for a committed person on conditional release is responsible for reporting to the court any violation of the conditions of placement. If a person on conditional release, whose conditions of placement include any service agreed to be provided by a CMHP, violates the conditions of conditional release, the director shall include in the clinical record a revocation report which documents the following:

(a) The person's noncompliance with those conditions of placement that include services provided by the CMHP;

(b) Efforts by the CMHP to inform the caregiver of the noncompliance and the caregiver's response to these efforts;

(c) Requests by the caregiver for the CMHP to assist in obtaining compliance from the committed person, or in notifying the court of the person's failure to comply with the conditions of placement, and the CMHP response to the requests for assistance;

(d) Documentation of the disposition made by the court, if the caregiver submits notification to the court; and

(e) The date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

(2) Outpatient commitment and trial visit. The director is responsible for reporting to the court any violation of the conditions of placement for persons on outpatient commitment (including community inpatient or outpatient treatment) or trial visit. For persons on outpatient commitment or trial visit, the director shall include in the clinical record a revocation report which includes the following:

(a) Documentation of the person's noncompliance with the conditions of placement;

(b) Documentation of efforts from all parties attempting to obtain compliance from the committed person and the response of the person to these efforts;

(c) A copy of the notification to the court of the person's failure to comply with the conditions of placement;

(d) Documentation of the disposition made by the court;

(e) Documentation of the distribution of any modified conditions of placement or disposition placing the person in inpatient treatment to all parties originally receiving copies of the conditions of placement; and

(f) Date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

Stat. Auth.: ORS 426.275
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0130

309-033-0330
Discharge of Committed Persons, Who Are Placed in the Community, from Commitment Status

(1) Only director of county of placement may discharge. Only the director of the county of placement may change the commitment status of a committed person placed in a community hospital or other community facility:

(a) The director shall discharge a person from commitment when:

(A) Release from treating facility. The director believes the committed person is no longer a mentally ill person as defined in ORS 426.005, and the person is to be released from the treating facility.

(B) Transfer to voluntary status. The director believes it is in the best interests of the person to transfer a committed person to voluntary status, but the person is to remain at the treating facility.

(b) The director shall discharge a person from commitment by notifying the last committing court and the court of residence, pursuant to the provisions of ORS 426.300.

(2) Discharge required unless new assignment and placement made. The director of the county of commitment shall discharge a person from commitment when a committed person is discharged from a hospital, nonhospital or residential facility, or an outpatient treatment program where the person has been assigned and placed unless the director of the county of commitment assigns and places the person with another provider of service as provided by OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division.

(3) Persons required to notify director prior to discharge. The following persons shall notify the director of the county of commitment 48 hours before discharging a person from a hospital, nonhospital or residential facility, or outpatient treatment:

(a) If the committed person is in a state hospital, the superintendent or designee shall notify the director;

(b) If the committed person is in a hospital serving as a regional acute care hospital or a private hospital, the treating physician shall notify the director;

(c) If the committed person is in a nonhospital or residential facility, the administrator of the facility shall notify the director;

(d) If the person is on trial visit, outpatient commitment or conditional release receiving outpatient treatment, and is not living in a nonhospital or residential facility, the administrator of the program where the person is receiving outpatient treatment shall notify the director.

(4) Procedures for discharge. The director shall give written notice to the committed person within thirty days after the commitment

was terminated. The notice shall state the date the commitment expired or was terminated. A copy of the notice shall be kept in the person's clinical record.

Stat. Auth.: ORS 426.300
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0140

309-033-0340
Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0150

Standards for Transportation and Transfer of Persons in Custody or on Diversion

309-033-0400
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.060, 426.072(3), 426.075, 426.110(2), 426.120, 426.140(2), 426.170, 426.180, 426.217, 426.220, 426.225, 426.228, 426.231, 426.232, 426.233, 426.236, 426.241(5), 426.495, 426.500, 430.041, and 430.205 through 430.210 and carry out the provisions of ORS 426.005 through 426.309.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0000

309-033-0410
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(3) "Community hospital" means any hospital that is not a state hospital.

(4) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(5) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer or approved secure transport provider pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer or approved secure transport provider at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(6) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer or approved secure transport provider to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(7) "Director of the county of commitment" means the director for the county where the person is committed.

(8) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(9) "Mechanical Restraint" is any object or apparatus, device or contraption applied or affixed to the person to limit movement, and includes, but is not limited to handcuffs, leg irons, soft restraints or Posey Strait Jacket.

(10) "Secure transport provider" means any service which uses privately or publicly owned motor vehicles, other than city, county or state police, to transport Persons in Custody or on Diversion to an Approved Holding Hospital or NonHospital Facility.

(11) "State hospital" means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(12) "Superintendent" means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0010; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0420
Transportation and Transfer of Persons in Custody or On Diversion

(1) Notification of court. The director shall immediately inform the court of a transfer and the location of the person and of the time the person is admitted to a new hospital or nonhospital facility.

(2) Transfer of persons in custody or on diversion. The director may transfer a person who is in custody or on diversion only when:

(a) The director believes there is an approved facility available that can provide necessary care or treatment which is sufficient to meet the emergency psychiatric needs of the person;

(b) The facility is approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, to provide care, custody and treatment of persons in custody or on diversion;

(c) The director has obtained the consent required by OAR 309-033-0420(3), Consent by Treating Physician and Receiving Physician or Director for Transfer Between Hospitals, through 309-033-0420(4), Consent by Treating Physician for Transfer from Nonhospital Facility to Hospital.

(3) Consent by treating physician and receiving physician or director for transfer between hospitals. If the transfer is from a hospital to another hospital or to a nonhospital facility, the director shall obtain the consent of the treating physician, and the receiving physician or the director of the nonhospital facility, prior to transferring the person:

(a) The treating physician shall give consent by writing in the person's clinical record an order over the physician's signature within 24 hours of giving verbal, telephonic or facsimile consent;

(b) The receiving physician at a hospital or the administrator of a nonhospital facility shall accept the transfer orally or telephonically, and shall document the acceptance in the clinical record of the person.

(4) Consent by treating physician for transfer from nonhospital facility to hospital. If the transfer is from a nonhospital facility to a hospital, the director shall obtain the consent of the receiving physician prior to transferring the person:

(a) The receiving physician shall give consent by writing in the person's clinical record an order over the physician's signature within 24 hours of giving verbal, telephonic or facsimile consent to admit the person to the hospital;

(b) The director shall provide the nonhospital facility written approval of the transfer within 24 hours of giving verbal, telephonic or facsimile approval of the transfer;

(c) The administrator of the nonhospital facility shall document the director's verbal or telephonic approval and retain written approval of the transfer in the clinical record of the person.

(5) Consent by administrator for transfer between nonhospital facilities. If the transfer is from one nonhospital facility to another nonhospital facility, the director shall obtain the verbal, telephonic or facsimile consent of the administrator of the receiving nonhospital facility prior to transferring the person:

(a) The administrator of the receiving nonhospital facility shall consent to the transfer by documenting in the person's clinical record the consent within 24 hours of giving verbal, telephonic or facsimile consent;

(b) The director shall provide the nonhospital facility written approval of the transfer within 24 hours of giving verbal, telephonic or facsimile approval of the transfer;

(c) The administrator of the sending nonhospital facility shall document the director's verbal, telephonic or facsimile approval and retain written approval of the transfer in the clinical record of the person.

(6) Notice to person to be transferred. Except in cases of emergency, twenty-four hours before the transfer is to take place, the director shall provide a notice to the person to be transferred which includes:

(a) Transfer date and time;

(b) A statement that the person may use the grievance procedure; and a brief description of how to initiate a grievance; and

(c) Justification for the transfer.

Stat. Auth.: ORS 426.060 & 426.235
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0030

309-033-0430
Transportation of a Committed Person to a State Hospital, Community Hospital or Nonhospital Facility

(1) Transportation of a committed person to a state hospital, community hospital or nonhospital facility. The director of the county of commitment shall arrange for the transportation of committed persons to the hospital or nonhospital facility:

(a) Only committed persons who have received prior approval for admission by the superintendent may be transported to a state hospital;

(b) A guardian, friend or relative may transport the committed person to the designated facility if all the following are met:

(A) The guardian, friend, or relative requests to transport the person to the designated facility prior to or at the time of the commitment hearing;

(B) The committing judge at the commitment hearing determines that the means of transportation would not be detrimental to the welfare of the mentally ill person or to the public.

(2) Medically unstable committed persons. The costs of providing care, custody and treatment for a committed person who is unable to be transported or cannot be admitted to a state hospital because of medical necessity shall be paid by the county of residence from funds provided it by the Division for the provision of mental health services. The hospital or other facility shall charge to and collect from the county of residence only after the hospital or other facility has charged to and collected from the person, third party payers or agencies otherwise legally responsible for the costs of emergency care, custody and treatment, as it would for any other patient.

(3) Transfer of a committed person to another hospital. The administrator of a facility caring for a committed person may transfer the person only with the recommendation of the director of the county of residence and the approval of the administrator of the receiving facility.

(4) Transfer of a committed person to voluntary status or discharge for commitment. The superintendent of a state hospital, on his/her own initiative or on the request of the committed person, shall transfer the committed person to voluntary status if the superintendent believes with reasonable medical certainty that the person will pursue voluntary treatment. The superintendent of a state hospital may discharge the person from commitment when the person meets the criteria for discharge in OAR 309-031-0210(2), Criteria for Admission to and Discharge from State or Other Adult Inpatient Psychiatric Hospitals:

(a) The administrator of a community hospital or nonhospital facility, other than a state hospital, caring for the committed person, in consultation with the director, may transfer the person to voluntary status or discharge the person from commitment;

(b) When a person is transferred to voluntary status, the superintendent or administrator shall notify the director and the court of the county of current commitment of such action within 72 hours;

(c) Any committed person transferred to voluntary status shall be discharged from the treating facility, at the request of the person or his legal guardian, within 72 hours of the request unless the person meets the criteria for prehearing custody and is placed in custody, thus initiating the commitment process.

(5) Grievance of transfer. The director and the superintendent shall have written procedures for resolving grievances about the transfer of committed persons from one facility to another. The director or the superintendent shall suspend the transfer of the person, until the grievance procedure is completed, unless immediate transfer is necessary for health or safety, upon the written or verbal protest of one of the following persons:

(a) The person being transferred;

(b) The legal guardian of the person being transferred.

Stat. Auth.: ORS 426.150
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0040

309-033-0432
Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or On Diversion to an Approved Holding Hospital or Nonhospital Facility

(1) Approved Secure transport provider. A Secure transport provider must be approved by the Division under this rule in order to transport a person pursuant to the provisions of ORS 426.228, 426.231, and 426.233. A Secure transport provider approved under this rule may transport the person only to a hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion.

(2) Application for approval. A Secure transport provider shall submit a letter of application to the Division. If approved, a certificate of approval will be issued to the Secure transport provider to provide such services. This approval shall be renewed every two years subject to the application of the Secure transport provider and review by the Division.

(3) Requirements for approval include all of the following:

(a) Secure transport providers must comply with the requirements OAR 309-033-0450, Client Rights with Regards to a Secure Transport Provider, and OAR 309-033-0460, Mechanical Restraint by a Secure Transport Provider.

(b) The governing body of the county in which the secure transport is to be used shall submit a letter formally authorizing the Secure transport provider to Transport Persons in Custody or on Diversion.

(c) The director in the county in which the secure transport is to be used shall submit a letter of recommendation for approval to the Division on behalf of the Secure transport provider.

(d) The vehicles of the Secure transport provider must:

(A) Have a secured rear seat in an area separated from the driver:

(B) Have a safety shield that prohibits physical contact with the driver;

(C) Have plexiglass or secured window guards covering any windows in the secured area;

(D) Be washable and nonbreakable in the secured area;

(E) Be absent of inside locks or door handles in the secured area;

(F) Have wrist and ankle restraints (preferably soft non-metal) for use when necessary to control violent or overt behavior;

(G) Be absent of any foreign item(s) or instrument(s) in the secured area that may be used by the client to inflict harm to self, attendant or person accompanying client;

(H) Have an operating cellular phone or other communication device for use in transit;

(I) Have adequate ventilation/heating appropriate to the secured seating.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0435
Client Rights with Regards to a Secure Transport Provider

(1) A secure transport provider shall maintain written policies and procedures with regard to client rights. The policies and procedures must assure that a client has the right to be treated with consideration, respect, and full recognition of human dignity and individuality. These rights are in addition to any other rights provided for in law.

(2) The client care policies and procedures must include but are not limited to:

(a) Considerate and respectful care;

(b) Reasonable privacy concerning a client's transportation and care;

(c) Confidentiality of all communications and records relating to client transportation and care except to the extent otherwise required by law;

(d) An environment in the secure transport that is free from recognized hazards.

(3) A secure transport provider shall keep a record of any formal complaint or report of misconduct made against an employee. The record must contain a copy of the complaint or report or a detailed written summary of the allegation. A provider shall investigate the accuracy of the complaint, report, or allegation and shall include a summary of the investigation and resulting action taken, if any, in the record. These records must be included in the driver's file with a copy provided to the Division.

(4) A secure transport provider shall report any client abuse in accordance with OAR 309-040-0200 through 309-004-0290.

(5) A secure transport provider shall obtain criminal offender information on all employees who are Transporting a Person in Custody or on Diversion in accordance with OAR chapter 410, division 007.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00; MHS 5-2007, f. & cert. ef. 5-25-07]

309-033-0437
Mechanical Restraint by a Secure Transport Provider

(1) A mechanical restraint may be used by secure transport providers in emergency situations to prevent a person from inflicting immediate and serious harm to self or others, or property. A mechanical restraint shall only be used for health and safety reasons. Mechanical restraint that results in injury to the person requires immediate written notification to the Division.

(2) Checking a person in a mechanical restraint:

(a) The provider shall monitor the client's need for adequate circulation.

(b) Staff shall document that the client was checked and appropriate attention paid to the person's needs.

(3) A Secure transport provider shall have adequately trained employees who are transporting a person in custody or on diversion.

(a) The employee shall participate in four hours of training annually. The training curriculum shall include: the management of aggressive behavior, the proper application of mechanical restraint and standards for the proper use of mechanical restraint.

(b) The employee shall be certified in cardiopulmonary resuscitation.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0440
Variance

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.060 & 426.235
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0050; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; Administrative correction 11-17-00

Standards for the Approval of Facilities that Provide Case, Custody and Treatment to Committed Persons in Custody or On Diversion

309-033-0500
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards for the approval of facilities that provide involuntary care, custody and treatment to persons in protective custody, in custody and on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.060, 426.072(3), 426.075, 426.110(2), 426.120, 426.140(2), 426.170, 426.180, 426.217, 426.220, 426.225, 426.228, 426.231, 426.232, 426.233, 426.236, 426.241(5), 426.495, 426.500, 430.041, and 430.205 through 430.210 and carry out the provisions of ORS 426.005 through 426.309.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0000

309-033-0510
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Service Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and

alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community hospital" means any hospital that is not a state hospital.

(6) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(7) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(12) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0010

309-033-0520
Classes of Facility that Provide Care, Custody or Treatment to Committed Persons or to Persons In Custody or On Diversion

(1) Division to assign classification. The Division shall assign a classification to a facility approved to serve a person committed to the Division under ORS 426.130, or a person in custody pursuant to ORS 426.232, 426.233, or on diversion pursuant to 426.237.

(2) Class 1. A Class 1 facility is a facility that is approved under applicable administrative rules to be locked to prevent a person from leaving the facility, to use seclusion and restraint, and to involuntarily administer psychiatric medication. This class of facility includes:

(a) A state hospital;

(b) A hospital, regional acute psychiatric care facility or other nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion;

(c) A facility which, in the opinion of the Division, restricts the liberty of a person to substantially the same degree as other facilities in this class.

(3) Class 2. A Class 2 facility is a facility that is approved under applicable administrative rules to be locked to prevent a person from leaving the facility. This class of facility includes:

(a) A secure residential facility that is approved under OAR 309-035-0100 through 309-035-0190, Residential Care Facilities for Mentally or Emotionally Disturbed Persons, and that is approved by the Division to be locked to prevent a person from leaving the facility;

(b) A facility which, in the opinion of the Division, restricts the liberty of a person to substantially the same degree as other facilities in this class.

(4) Class 3. A Class 3 facility is a residential facility that is approved under OAR 309-035-0100 through 0309-035-0190, Residential Care Facilities for Mentally or Emotionally Disturbed Persons. A Class 3 facility shall not lock its doors to prevent a person from leaving the facility.

Stat. Auth.: ORS 426.238
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0030

309-033-0530
Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons In Custody and On Diversion

This section establishes rules for approval of hospital and nonhospital facilities which provide service to a committed person or to a person in custody or on diversion.

(1) Approved hospitals and other facilities. Only hospitals and nonhospital facilities, approved by the Division under this rule, shall provide care and treatment services for committed persons or for persons in custody or on diversion.

(2) Application for approval. Approval of hospitals or nonhospital facilities shall be accomplished by submission of a letter of application. If approved, a Certificate of Approval will be issued to the hospital or nonhospital facility to provide such services. This approval shall be reviewed on a biennial basis subject to application of the hospital or other facility and/or review by the Division.

(3) Requirements for approval. In undertaking review of the hospital or nonhospital facility for approval, the Division shall be satisfied that the hospital or nonhospital facility meets one of the following requirements:

(a) Approval to provide seclusion and restraint considered approval to provide services to committed persons and to persons in custody and on diversion. The Division shall approve, without further requirement, hospitals and nonhospital facilities currently approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) Requirements for facilities not approved to provide seclusion and restraint. The Division shall approve a nonhospital facility to serve committed persons and persons in custody and on diversion if the nonhospital facility is certified as a secure residential facility under Division rules and the nonhospital facility has the following:

(A) Written policies and procedures in place which assure that:

(i) The facility shall not admit a person who may require seclusion or physical restraint.

(ii) A person who develops the need for seclusion and restraint is immediately removed to a hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(iii) Each person admitted to the facility has a physician who is responsible for treating the person during the person's stay at the facility and who examines the person within 24 hours of the person's admission to the facility.

(iv) A staff person shall provide direct care for consumers only when that staff person is trained in the curriculum approved by the psychiatrist or psychiatric nurse practitioner. The staff shall receive the training within the last six months prior to providing direct consumer care.

(v) A staff person shall participate in the training approved by the psychiatrist or psychiatric nurse practitioner quarterly.

(B) A psychiatrist or a licensed psychiatric nurse practitioner, who is employed by the facility or has a contract with the facility, to provide medical oversight of admission policies and procedures, and staff training.

(C) A staff training curriculum which is approved by the psychiatrist or nurse practitioner and includes:

(i) Criteria for the admission of a person who can safely be served by the nonhospital facility;

(ii) Recognition of indicators of violence or assault and criteria for the transfer of person to a more secure facility;

(iii) Indicators of medical problems, identification of medication side effects, and indicators of medical problems and medical crisis; and

(iv) Management of aggressive behavior and de-escalation techniques.

(D) Two qualified mental health associates who are available on-site 24 hours-a-day, seven days-a-week.

(E) Alarmed doors and windows which have been approved by the Division.

(F) A written agreement with a law enforcement agency to respond to emergencies that provides:

(i) Emergency response time within 15 minutes of the nonhospital facility's request.

(ii) Agreement by the law enforcement agency to retake a person who elopes and to return the person to the nonhospital facility or remove the person to a hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion, as directed by the administrator of the nonhospital facility.

(G) Documentation of fire marshal approval to operate as a secure facility.

Stat. Auth.: ORS 426.228, 426.232, 426.233 & 426.236
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0040

309-033-0540
Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons In Custody

(1) Written policies. Each hospital or nonhospital facility shall have written policies concerning the care, custody, and treatment of persons in custody or on diversion. These policies shall be written to provide for the comfort and safety of the person being provided care and for the safety of the facility staff providing care to that person. These policies shall detail staff responsibilities, person's rights, and emergency procedures. All staff involved in the care of these persons shall be fully familiar with these policies and procedures. These policies shall be reviewed as part of the Division's approval process.

(2) Warning. Each hospital or nonhospital facility shall:

(a) Have a physician, nurse or QMHP give the person the following warning:

"You are being held in this hospital because someone is concerned that you may hurt yourself or other people. Anything the staff of this hospital observes you do or say while you are in custody here may be used as evidence in a court of law to determine whether you should be committed as a mentally ill person. You have a right to legal counsel. If you cannot afford an attorney one will be provided for you by the court."

(b) Have the warning given at the time of admission and at times when it is determined that the person will reasonably understand the notice, and as often as it is determined necessary to assure that the person has been given an opportunity to be aware of the notice.

(c) Have the warning given to the person in writing, as required by ORS 426.123(2). An attempt shall be made to have the person sign the written warning. A copy of the signed written warning shall be given to the person and the original shall be kept in the clinical record. The person's inability to sign the written warning or refusal to sign the written warning shall be documented on the written warning below the place where the person's signature would be normally found, clearly stating the reasons the signature was not obtained. The written warning shall include a place where the person, by making a mark, may request legal counsel.

(3) Notification of next of kin. If the person consents, a physician, nurse or QMHP at a hospital shall make every effort to notify the person's next of kin of the location and condition of the person as required under ORS 426.234(1)(e).

(4) Notification of the court of hospital hold. The admitting physician, if the person is at a hospital, shall immediately notify the circuit court in writing. The admitting physician shall also immediately notify the director in the county where the hospital is located so that an investigation can be conducted.

(5) Notification of the court of nonhospital hold. The director, if the person is at a nonhospital facility, shall notify, in writing, the circuit court in the county where the person was taken into custody.

(6) Log. Each hospital or nonhospital facility shall maintain a log of persons in custody that includes: name, date of birth, date of admission, type of admission and a notation of the use of restraints.

(7) Posted warning and rights. Each hospital or nonhospital facility shall post a copy of the person's rights in the holding room behind protective unbreakable plastic or in another location clearly visible from the holding room which, at a minimum, states:

(a) The warning described in OAR 309-033-0540(2)(a);

(b) The person's right to be free from electro-shock therapy or unduly hazardous procedures.

(8) Clinical records. Each hospital or nonhospital facility shall maintain a clinical record which accurately documents the care, custody and treatment of a person in custody. These records shall include:

(a) A copy of the hold form which documents the reasons for the hold, including specific behaviors which indicate the person:

(A) Is dangerous to self or another person; and

(B) Is in need of immediate care, custody or treatment for mental illness.

(b) Documentation that the warning described in OAR 309-033-0540(2) has been given to the person.

(c) Documentation of the potential effects and the observed effects of any medication administered which may substantially affect the person to prepare for or function effectively at the commitment hearing, signed by the treating physician.

(d) A report of physical examination and relevant laboratory tests.

(e) Daily medical progress notes.

(f) Twenty-four hour nursing notes.

(g) Documentation, signed by the treating physician, of each use of any mechanical restraints and the specific reasons which justify the use.

(h) Documentation of the psychiatric history which, whenever possible, shall include:

(A) History of present illness, including specific prodromal symptoms;

(B) Medical history;

(C) Family history;

(D) Past psychiatric history;

(E) Substance use and abuse history;

(F) History of legal difficulties; and

(G) Social history including current support system.

(i) A report of mental status.

(j) A diagnostic impression.

(k) A treatment plan.

(9) Access to clothing before release of persons in custody. Each hospital or nonhospital facility shall allow the person in custody to have access to his/her clothing before being released to attend the commitment hearing.

Stat. Auth.: ORS 426.123, 426.232, 426.233, 426.234 & 426.236
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0050

309-033-0550
Standards for the Approval of Hospitals Detaining Persons In Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility

(1) Approved hospitals. Only hospitals approved by the Division under this rule may detain a person pending transport pursuant to the provisions of ORS 426.231. A hospital approved under this rule may transport the person only to a hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion. Hospitals approved under OAR 309-033-0530 are also approved under this rule to detain a person pending transport and may transport a person to another hospital or nonhospital facility approved under OAR 309-033-0530.

(2) Application for approval. Approval of hospitals shall be accomplished by submission of a letter of application in accordance with administrative rules on letters of approval. If approved, a certificate of approval will be issued to the hospital to provide such services. This approval shall be renewed on a biennial basis subject to the application of the hospital or review by the Division.

(3) Requirements for approval. The director in the county in which the hospital is located shall submit a letter of recommendation for approval on behalf of the hospital. The letter of recommendation shall clearly state that the director and the hospital have a written agreement which includes the following:

(a) The procedures to be followed when a person is detained or transported to another hospital or nonhospital facility, with the parties responsible for performing the procedures clearly identified. The procedures shall state whether or not the hospital is required to give notice to the director prior to the release of the person.

(b) The party or parties responsible for transporting the person to another hospital or nonhospital facility and the means by which such transportation is initiated and authorized.

(c) The services to be provided by the hospital when a person is detained and transported to another hospital or nonhospital, and the payment the hospital is to receive for these services.

(d) The hospital shall have a room which meets OAR 309-033-0720(3)(f), Application and Requirements for Approval to Provide Seclusion and Restraint, or shall provide an attendant to provide continuous face-to-face monitoring of the person.

(4) Responsibilities of the physician. The physician shall complete a face-to-face examination of the person. Once the physician determines that the person is dangerous to self or any other person and in need of emergency care or treatment for mental illness, the physician shall:

(a) Assure the detention of the person in safe and humane quarters for no longer than 12 hours;

(b) Assure that the person is monitored face-to-face every 15 minutes;

(c) Consult with a physician who has admitting privileges at a receiving hospital or nonhospital facility approved by the Division to determine that the receiving physician:

(A) Agrees that the person appears to be dangerous to self or any other person; and

(B) Consents to receive the person for further evaluation for involuntary emergency care and treatment for mental illness.

(d) If the person is to be sent to the receiving hospital, complete a written statement that states:

(A) The physician has examined the person within the preceding 12 hours;

(B) The reasons the physician has found the person to be dangerous to self or any other person and is in need of emergency care or treatment for mental illness; and

(C) The name of the admitting physician at the receiving hospital who has agreed to transporting the person for further evaluation and possible admission.

(e) Retain a copy of the written statement in the person's clinical record. The original written statement shall accompany the person to the receiving hospital and shall serve as authorization for transport.

(5) Release when person is no longer dangerous. If the physician at the hospital where the person is detained and is awaiting transport believes the person is no longer dangerous to self or any other person, then the physician shall release the person as soon as possible. If the physician cannot locate a receiving hospital where a physician agrees to receive the person for evaluation, then the person shall be released within twelve hours of the time the person was originally detained.

Stat. Auth.: ORS 426.231
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0060

309-033-0560
Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0070

Standards for Obtaining Informed Consent to Treatment from a Person and the Administration of Significant Procedures without the Informed Consent of a Committed Person at Community Hospitals, Nonhospital Facilities, and Residential Facilities Approved by the Division

309-033-0600
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for community hospitals, nonhospital facilities and residential facilities relating to obtaining informed consent to treatment from a committed person, and for the administration of significant procedures without obtaining the informed consent of a committed person.

(2) Statutory authority. These rules are authorized by ORS 426.385 and 430.041 and carry out the provisions of ORS 426.005 through 426.309.

Stat. Auth.: ORS 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0000

309-033-0610
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community hospital" means any hospital that is not a state hospital.

(6) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(7) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(11) "Legally incapacitated person" means a person who has been found by the court to be unable to give informed consent to medical treatment and the court has appointed a guardian to make such decisions on the person's behalf pursuant to ORS 126.098 through 126.143.

(12) "Material risk" means the risk may have a substantial adverse effect on the patient's psychological and/or physical health. Tardive dyskinesia is a material risk of neuroleptic medication.

(13) "Nurse" means a registered nurse or a psychiatric nurse practitioner licensed by the Oregon Board of Nursing, but does not include a licensed practical nurse or a certified nurse assistant.

(14) "Person" means a consumer of mental health services committed to the Division who is admitted to a community hospital, nonhospital facility or residential facility for care, custody or treatment of mental illness.

(15) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(16) "Psychologist" means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

(17) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(18) "Significant procedure" means a diagnostic or treatment modality which poses a material risk of substantial pain or harm to the patient or resident such as, but not limited to, psychotropic medication and electro-convulsive therapy.

(19) "Superintendent" means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0010

309-033-0620
Obtaining Informed Consent to Treatment From a Person and the Administration of Significant Procedures Without the Informed Consent of a Committed Person

(1) Basic rule for obtaining informed consent to treatment from a person. A person or a guardian, on behalf of a legally incapacitated committed person, may refuse any significant procedure and may withdraw at any time consent previously given to any significant procedure.

(2) Documentation of withdrawal of consent. Any refusal or withdrawal or withholding of consent shall be documented in the person's record.

(3) Exceptions to obtaining informed consent from a person. Personnel of a facility shall not administer a significant procedure to a committed person unless informed consent is obtained from or on behalf of the person in the manner prescribed in OAR 309-033-0620, except as follows:

(a) Administration of significant procedures without informed consent in emergencies (OAR 309-033-0630); and

(b) Involuntary administration of significant procedures with good cause to persons committed to the Division (OAR 309-033-0640).

(4) Capacity of the committed person. Unless adjudicated legally incapacitated for all purposes or for the specific purpose of making treatment decisions, a person shall be presumed competent to consent to, or refuse, withhold, or withdraw consent to significant procedures.

(a) A physician shall deem a person unable to consent to or refuse, withhold, or withdraw consent to a significant procedure only if the person currently demonstrates an inability to comprehend and weigh the risks and benefits of the proposed procedure, alternative procedures, or no treatment at all or other information disclosed pursuant to OAR 309-032-0620(5)(a). Such inability is to be documented in the person's record and supported by documented statement or behavior of the person.

(b) A person committed to the Division shall not be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure merely by reason of one or more of the following facts:

(A) That the person has been involuntarily committed to the Division;

(B) That the person has been diagnosed as mentally ill;

(C) That the person has disagreed or now disagrees with the treating physician's diagnosis; and

(D) That the person has disagreed or now disagrees with the treating physician's recommendation regarding treatment.

(c) If a court has determined that a committed person is legally incapacitated with regard to medical treatment decisions, then consent shall be sought from the legal guardian.

(5) Procedures for obtaining informed consent and information to be given.

(a) The person from whom informed consent to a significant procedure is sought, as required by ORS 677.097, shall be given information regarding:

(A) The nature and seriousness of the committed person's mental illness or condition;

(B) The purpose and method of the significant procedure, its intended outcome and the risks and benefits of the procedure and when neuroleptic medication is prescribed, that tardive dyskinesia is a risk;

(C) Any alternatives that are reasonably available and reasonably comparable in effectiveness; and

(D) Any additional information concerning the proposed significant procedure requested by the person.

(b) The physician intending to administer a significant procedure shall document in the person's chart that the information required in OAR 309-033-0620(3)(a) was explained and that the person or guardian of a legally incapacitated person or resident explicitly consented, refused, withheld or withdrew consent.

(6) Voluntary consent. Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion. Subject to the provisions of OAR 309-033-0640, Involuntary Administration of Significant Procedures to Committed Person with Good Cause, and OAR 309-033-0260, Diversion from Commitment Hearing, the decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing withholding to or withdrawing consent. A voluntary person may be discharged from the facility if offered procedures are refused.

(7) Obtaining consent with respect to legally incapacitated persons. A facility may not administer a significant procedure to a legally incapacitated committed person without the consent of the guardian, except in the case of an emergency.

(8) Reports of progress. The person or the guardian of a legally incapacitated person shall, upon request, be informed of the progress of the person during administration of the significant procedure.

(9) Right to appeal. A person has the right to appeal the application of any provision of these rules as provided in the grievance

policies and procedures of the facility. If the committed person is legally incapacitated, the guardian has the right to appeal the application of any provision of these rules by using the grievance procedures.

Stat. Auth.: ORS 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0030

309-033-0625
Administration of Medication and Treatment without the Informed Consent of a Person in Custody

(1) Hospitals or Nonhospital Facilities Authorized. Only a physician at a hospital or nonhospital facility approved under OAR 309-033-0500 through 309-033-0560 may administer medication and treatment without the informed consent of a person in custody.

(2) What constitutes an emergency. The fact that a person is in custody under the provisions of ORS 426.232 or 426.233 shall not be the sole justification that an emergency exists. An emergency exists if in the opinion of the physician, and either a consulting physician or qualified mental health profession:

(a) Immediate action is required to preserve the life or physical health of the person and it is not practical to obtain informed consent as provided in OAR 309-033-0620(5); or

(b) Immediate action is required because the behavior of the person creates a substantial likelihood of immediate physical harm to the person, or others in the facility and it is not practical to obtain informed consent as provided in OAR 309-033-0620(5).

(3) Grounds for the administration of medication and treatment without informed consent. As provided by ORS 426.072(2)(c), a physician shall administer medication and treatment to a person in custody without obtaining prior informed consent, only in the following circumstances:

(a) If an emergency exists as described in OAR 309-033-0625(2), or

(b) If the physician, in consultation with another physician or qualified mental health profession, the person is unable to give informed consent as described in OAR 309-033-0620(4)(a).

(4) Procedures and limitations for the administration of medication or treatment without consent. When administering medication or treatment without the informed consent of a person in custody, the physician shall:

(a) Administer medication and treatment in accordance with medical standards in the community;

(b) Not administer electro-shock therapy or unduly hazardous treatment as set forth in ORS 426.072(2)(c);

(c) Document in the person's record the specific nature of each emergency and the procedure that was used to deal with the emergency, or if the person is unable to give consent, document that fact in the person's record;

(d) If the person is a minor or has a guardian, make a reasonable effort to contact the legal guardian prior to the administration of medication or treatment, but if efforts to contact the guardian are not successful, the physician may only administer medication or treatment in an emergency and shall notify the legal guardian as soon as possible, otherwise the physician shall not administer medication until consent is obtained from the guardian;

(e) Review the medication and treatment with the treatment team within a reasonable period of time after the medicine or treatment is administered without consent and, if applicable, administer medication or treatment designed to correct the behavior creating the emergency;

(f) Not continue to administer medication or treatment after the emergency has subsided or the person has regained the ability to consent to treatment, without obtaining the person's informed consent; and

(g) Immediately proceed as provided in OAR 309-033-0600 through 309-033-0650 if the person who was in custody is committed and the physician believes the person remains unable to give consent and it is necessary to continue involuntary administration of medication or treatment; the physician may only continue the administration of medication or treatment under the provisions of OAR 309-033-0625 for seven days pending a decision under OAR 309-033-0640.

Stat. Auth.: ORS 426.072, 426.231 & 426.236
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHS 5-2007, f. & cert. ef. 5-25-07

309-033-0630
Administration of Significant Procedures in Emergencies Without the Informed Consent of a Committed Person

(1) Hospitals or nonhospital facilities authorized. The following facilities that serve committed persons and which administer significant procedures in emergencies, without obtaining informed consent, shall be subject to the provisions of 309-033-0630:

(a) A hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Approval of Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) A hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities To Provide Services to Committed Persons and to Persons in Custody or on Diversion.

(c) Secure residential facilities licensed by the Division, or licensed by the Senior and Disabled Services Division (SDSD).

(d) Intermediate care facilities or enhanced care facilities licensed by the Senior and Disabled Services Division (SDSD).

(2) What constitutes an emergency. An emergency exists if in the opinion of the responsible physician or nurse:

(a) Immediate action is required to preserve the life or physical health of the committed person and it is impracticable to obtain informed consent as provided in OAR 309-033-0620; or

(b) Immediate action is required because the behavior of the committed person creates a substantial likelihood of immediate physical harm to the committed person or others in the facility and it is impracticable to obtain informed consent as provided in OAR 309-033-0620(5), Procedures for Obtaining Informed Consent and Information to be Given.

(3) Administering a significant procedure. If an emergency exists, the responsible physician or nurse may administer a significant procedure to a committed person without obtaining prior informed consent in the manner otherwise required by these rules, provided:

(a) The physician or designee shall document in the person's clinical record the specific nature of each emergency and the procedure which was used to deal with the emergency.

(b) If the person is legally incapacitated, the physician or designee shall make reasonable effort to contact the legal guardian prior to the administration of the significant procedure. If contact is not possible, the physician or designee shall notify the legal guardian as soon as possible.

(c) Within a reasonable period of time after an emergency procedure is administered, the treatment team shall review the treatment and, if practicable, implement treatment designed to correct the behavior creating the emergency.

(d) The responsible physician or nurse shall not administer a significant procedure after the emergency situation has subsided, without obtaining informed consent.

Stat. Auth.: ORS 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0040

309-033-0640
Involuntary Administration of Significant Procedures to a Committed Person With Good Cause

(1) Hospitals or nonhospital facilities authorized. Only the following facilities that serve committed persons shall involuntarily administer significant procedures with good cause under the provisions of 309-033-0640:

(a) A hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Approval of Hospitals and Nonhospital Facilities To Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) A hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities To Provide Services to Committed Persons and to Persons in Custody or on Diversion.

(c) Secure residential facilities licensed by the Division or licensed by the Senior and Disabled Services Division (SDSD).

(d) Intermediate care facilities or enhanced care facilities licensed by SDSD which have a variance from SDSD to provide involuntary medication.

(2) Good cause. Good cause exists to administer a significant procedure to a person committed to the Division without informed

consent if, in the opinion of the treating physician, after consultation with the treatment team:

(a) The person is deemed unable pursuant to OAR 309-033-0620(4) to consent to, refuse, withhold or withdraw consent to the significant procedure.

(b) The proposed significant procedure will likely restore, or prevent deterioration of, the person's mental or physical health, alleviate extreme suffering, or save or extend the person's life.

(c) The proposed significant procedure is the most appropriate treatment for the person's condition according to current clinical practice, and all other less intrusive procedures have been considered and all criteria and information set forth in OAR 309-033-0620(5), Procedures for Obtaining Informed Consent and Information to be Given, are considered.

(d) The treating physician has made a conscientious effort to obtain informed consent to the significant procedure from the person.

(3) Independent review. Prior to granting approval for the administration of a significant procedure for good cause to a person committed to the Division, the administrator shall obtain consultation and approval from an independent examining physician.

(a) The administrator shall maintain a list of independent examining physicians and shall seek consultation and approval from independent examining physicians selected on a rotating basis from the list. The independent examining physician shall:

(A) Be a psychiatrist;

(B) Not be in a position to provide primary or on-call care or treatment to the person who is subject of the independent review;

(C) Not be an employee of the facility;

(D) Have been subjected to review by medical staff executive committee as to qualifications to make such an examination; and

(E) Have read and received training from the medical staff regarding the meaning and the application of these rules.

(b) Prior to seeking consultation and approval of an examining physician, the administrator shall provide written notice to the committed person who is subject to the proposed significant procedure without the person's consent.

(4) Independent physician activities. The physician selected to conduct the independent consultation shall:

(a) Review the person's clinical record, including the records of efforts made to obtain the person's informed consent;

(b) Personally examine the person;

(c) Interview the person to determine the extent of the need for the procedure and the nature of the person's refusal, withholding, or withdrawal or inability to consent to the significant procedure;

(d) Consider additional information, if any, presented prior to or at the time of examination or interview as may be requested by the person; and

(e) Make a determination whether the factors required under these rules exist for the particular person or that one or more factors are not present. If the physician determines that the person does not have capacity to give consent to treatment, the physician shall review the proposed significant procedure. The physician shall make his/her determination of capacity, approval or disapproval of the proposed significant procedure to:

(A) The administrator; and

(B) The person to whom a significant procedure is proposed to be administered, with a copy being made part of the person's record.

(5) Administrator determination. The administrator shall approve or disapprove of the administration of the significant procedure to a person committed to the Division based on good cause, provided:

(a) The administrator shall not approve the significant procedure and it shall not be performed when the independent examining physician found that one or more of the factors required by OAR 309-033-0640(2) were not present or otherwise disapproved of the procedure.

(b) Approval of the significant procedure shall terminate if there is a substantial increase in risk, as determined by a physician, of administering the significant procedure or at any time the person regains capacity to give informed consent/refusal. Approval of the significant procedure shall terminate at the end of the person's commitment but in no case longer than 180 days. Disapproval shall be only so long as no substantial change occurs in the person's condition.

(c) Written notice of the administrator's determination shall be provided to the person and made part of the committed person's clinical records.

(d) A copy of the independent examining physician's report shall be made part of the committed person's clinical record.

(6) Ninety-day right to review. The administrator shall adopt procedures which assure that the committed person may request independent review of the approval once every ninety days after the initial approval. Within 14 days of a verbal or written request from the committed person, the administrator shall initiate an independent review of the approval, as in OAR 309-033-0640(3) and 309-033-0640(4).

(7) Transfer of approval. The administrator, or the superintendent of a State hospital, shall transfer the approval of the administration of a significant procedure when a committed person is transferred to another hospital or nonhospital facility described in OAR 309-033-0640(1).

(a) The administrator, or the superintendent, of the sending hospital or nonhospital facility shall transfer the approval by sending copies of all approval documents to the administrator of the receiving facility.

(b) The administrator, or the superintendent, of the receiving hospital or nonhospital facility shall assure that the treating physician at that facility reexamines the committed person and verifies that the need for the approval continues to exist as described in OAR 309-033-0620(5), Procedures for Obtaining Informed Consent and Information to be Given, and 309-033-0640(2)(a) through 309-033-0640(2)(c), Good Cause. The receiving hospital or nonhospital facility may administer the significant procedure if the need for the procedure continues in accordance with OAR 309-033-0640, Involuntary Administration of Significant Procedures to a Committed Person with Good Cause.

(c) In no event shall the approval of a significant procedure continue beyond 180 days from the date of the original approval without reestablishing the need for the approval by following the procedures prescribed in OAR 309-033-0640, Involuntary Administration of Significant Procedures to Committed Persons with Good Cause.

(8) Administrative procedures.

(a) Utilization summary. Every four months the administrator shall make a summary of the use of OAR 309-033-0630 and 309-033-0640 that includes:

(A) Each type of proposed significant procedure for which consultation with an independent examining physician was sought;

(B) The number of times consultation was sought from a particular independent examining physician or disposition board for each type of proposed significant procedure;

(C) The number of times each independent examining physician approved and disapproved each type of proposed significant procedure; and

(D) The number of times the approved and disapproved each type of proposed significant procedure.

(b) Outside reviewer's access to summaries. The administrator shall provide a copy of a utilization summary to the federally-mandated advocacy and protection agency for Oregon, which is appointed by the Governor and which currently is the Oregon Advocacy Center, and the Division. The Division may only distribute the report to any other person or organization authorized by the Division which in the opinion of the Assistant Administrator:

(A) Has substantial interest in the advocacy and protection of the rights of persons with mental illness; and

(B) Whose access to the summaries will provide a substantial and material benefit to the citizens of Oregon.

Stat. Auth.: ORS 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0050

309-033-0650
Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0060

Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion

309-033-0700
Statement of Purpose and Statutory Authority

(1) Purpose. This section establishes rules pursuant to ORS 426.070, 426.180, 426.236, 426.228, 426.232, 426.233 and 426.234 for approval of community hospitals and nonhospital facilities which provide seclusion and restraint to committed persons and to persons in custody or on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.236, 426.385 and 430.041 and carry out the provisions of ORS 426.005 through 426.309.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0000

309-033-0710
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Service Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community hospital" means any hospital that is not a state hospital.

(6) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(7) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(12) "NMI" is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(13) "Nurse" means a registered nurse or a psychiatric nurse practitioner licensed by the Oregon Board of Nursing, but does not include a licensed practical nurse or a certified nurse assistant.

(14) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(15) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(16) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(17) "Restraints" means any chemical or physical methods or devices that are intended to restrict or inhibit the movement, functioning, or behavior of a resident.

(18) "Seclusion" means placing an individual in a locked room. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut.

(19) "State hospital" means Oregon State Hospital in Salem, Dammasch State Hospital in Wilsonville and Eastern Oregon Psychiatric Center in Pendleton.

(20) "Superintendent" means the chief executive officer of a state hospital, or designee, or, a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0010

309-033-0720
Application and Requirements for Approval to Provide Seclusion and Restraint

(1) Approved hospitals and other facilities. Only community hospitals and nonhospital facilities approved by the Division under this rule shall provide seclusion and restraint to committed persons and to persons in custody or on a diversion. Only the following facilities shall be approved:

(a) Community hospitals licensed by the Health Division; and

(b) Regional acute care facilities for adults approved by the Division.

(2) Application for approval. Approval of community hospitals or nonhospital facilities shall be accomplished by submission of a letter of application in accordance with administrative rules on letters of approval. If approved, a Certificate of Approval will be issued to the community hospital or nonhospital facility to provide seclusion and restraint. This approval shall be reviewed on a biennial basis subject to review by the Division.

(3) Requirements for approval. In undertaking review of the hospital or nonhospital facility for approval, the Division shall be satisfied that the hospital or other facility meets the following requirements:

(a) Medical staffing. Adequate staff shall be available at the hospital or nonhospital facility to provide emergency medical services which may be required. A letter from the chief of the medical staff of the hospital stating such availability shall constitute satisfaction of this requirement. For nonhospital facilities, a written agreement to provide such medical services between the facility and a local hospital or when such an agreement is not possible, a written agreement to provide such medical services between the facility and a local physician shall be adequate.

(b) Qualifications of direct care staff. A staff person shall provide direct care for consumers only when:

(A) A staff person is trained in seclusion and restraint.

(i) A new staff person shall be trained within the six months prior to providing direct consumer care.

(ii) Staff person shall participate in four hours of seclusion and restraint training annually. In addition, shall participate in an actual seclusion or restraint event which is debriefed, or an unannounced drill quarterly.

(iii) Training curriculum shall include: the management of aggressive behavior, the proper application of seclusion and restraint, standards for the proper use of seclusion and restraint as described by OAR 309-033-0730, Seclusion and Restraint Procedures, and indicators of a medical crisis.

(B) Staff shall demonstrate the ability to manage aggressive behavior within the standards for the proper use of seclusion and restraint as described by OAR 309-033-0730.

(c) Medical services. A physician shall be available 24 hours-a-day, seven days-a-week to provide medical supervision of the services provided. A physician shall examine a person admitted to the hospital or nonhospital facility within 24 hours of the person's admission.

(d) Health care supervision. The hospital or nonhospital facility shall appoint a physician, a psychiatric nurse practitioner, a master's level registered nurse or a registered nurse certified by the American Nursing Association as the health care supervisor. The health care supervisor shall review and approve policies and procedures relating to:

(A) The reporting of indicators of medical problems to a physician; and

(B) Curriculum for training staff including:

(i) Identification of medication side effects; and

(ii) Indicators of medical problems and medical crisis.

(e) Structural and physical requirements. The hospital or other facility which provides care, custody and treatment for persons who are considered dangerous to themselves or others shall have available at least one room which meets the following requirements:

(A) The room must be of adequate size, not isolated from regular staff of the facility, and provided with an adequate locking device on all doors and windows.

(B) The door must open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside and before entering.

(C) The room shall contain no protruding objects, such as doorknobs, towel or clothes bars, hooks, or racks. There shall be no exposed curtains, drapes, rods, or furniture, except a portable bed which can be removed, if necessary. In case of the removal of the bed frame, a fireproof mattress shall be placed on the floor. Beds which are securely fastened to the floor must have no protrusions such as bed posts or sharp corners.

(D) Any windows shall be made of unbreakable or shatterproof glass, or plastic. Non-shatterproof glass shall be protected by adequate detention type screening, such as Chamberlain Detention Screen.

(E) There shall be no exposed pipes or electrical wiring in the room. Electric outlets shall be permanently capped or covered with a metal shield which opens with a key. Ceiling and wall lights shall be recessed and covered with safety-type glass or unbreakable plastic. Any cover, cap or shield shall be secured by tamper-proof screws or other means approved by the Division.

(F) The room shall contain no combustible material, such as matches, lighters, cigarettes, etc. Smoking shall not be allowed in the room, except under direct supervision of staff.

(G) The room shall meet fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with a fine mesh metal screening. If pop-down type, sprinklers must have breakaway strength of under 80 pounds. In lieu of sprinklers, a combined smoke and heat detector shall be used. Documentation of the breakaway strength of sprinklers must be on file at the facility.

(H) Adequate toilet and sanitary facilities shall be available.

(I) The bathroom shall contain no shower rods, shower curtains, window curtain rods, curtains, or towel rods, unless used only with direct staff supervision.

(J) The bathroom shall not lock from the inside and, if connected to the room, shall be locked when not in use.

(K) No sharp objects, such as razor blades, scissors, knives, nail files, etc., shall be available to the patient, except under direct staff supervision. No poisons or cleaning materials shall be kept in the room or in the bathroom available for the room.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0030

309-033-0730
Seclusion and Restraint Procedures

(1) Seclusion and restraint use in accordance with rules. Approved hospitals or nonhospital facilities shall not use seclusion and restraint except in emergencies and only then subject to the conditions and limitations of these rules.

(2) General procedures.

(a) Only a physician or a nurse may initiate seclusion or restraint procedures.

(b) Supervision of seclusion and restraint. Each use of seclusion or restraint shall be monitored and supervised by a physician or a nurse.

(c) A physician shall approve the use of seclusion or restraint within one hour of the administration of the procedure. This approval shall be documented in the person's medical record. The physician's approval may be by the following methods:

(A) Verbally;

(B) Telephonically; or

(C) By facsimile.

(d) A physician shall order physical restraint for no longer than 14 hours.

(e) A physician shall examine a person within 14 hours of the administration of seclusion or restraint and the person shall be examined by a nurse every two hours until such time as a physician examines the person and makes new orders releasing the person from seclusion or restraint. The physician shall document to reasons for the use of the seclusion or restraint over the physician's signature.

(f) A physician shall not order physical restraint on an as required basis, i.e. a physician shall not make "p.r.n." orders for physical restraint.

(g) No form of restraint shall be used as punishment, for the convenience of staff, or as a substitute for activities, treatment or training.

(h) Medication will not be used as a restraint, but will be prescribed and administered according to acceptable medical, nursing and pharmaceutical practices.

(i) Patients shall not be permitted to use restraint on other patients.

(j) Physical restraint must be used in accordance with sound medical practice to assure the least risk of physical injury and discomfort. Any patient placed in physical restraint shall be protected from self-injury and from injury by others.

(k) Checking a patient in restraint:

(A) A patient in restraint must be checked at least every 15 minutes.

(B) Attention shall be paid to the patient's basic personal needs (such as regular meals, personal hygiene and sleep) as well as the person's need for good body alignment and circulation.

(C) Staff shall document that the patient was checked and appropriate attention paid to the person's needs.

(l) During waking hours the patient must be exercised for a period not less than 10 minutes during each two hours of physical restraint. Partial release of physical restraint shall be employed as necessary to permit motion and exercise without endangering other staff and patients.

(m) Unless the order authorizing use of restraint specifically provides otherwise, the patient shall be released as soon as it is reasonable to assume that the behavior causing use of restraint will not immediately resume if the person is released.

(3) Documentation.

(a) No later than the end of their work shifts, the persons who obtained authorization and carried out the use of restraint shall document in the person's chart including but not necessarily limited to the following:

(A) The specific behavior which required intervention;

(B) The methods of intervention used and the patient's responses to the interventions; and

(C) The reason this specific intervention was used.

(b) Within 24 hours after the incident resulting in the use of restraint, the treating physician who ordered the intervention shall review and sign the order.

(4) Time Limits. All orders authorizing use of restraint shall contain an expiration time, not to exceed 14 hours. Upon personal reexamination of the person, the treating physician may extend the order for up to 14 hours at each review, provided that the behavior of the person justifies extended intervention. After each 24 hours of continuous restraint, a second opinion from another physician who has examined the person shall be required for further extension of the restraint.

(5) Reporting. All emergency uses of restraint in excess of 15 minutes shall be reported daily to the health care supervisor.

(6) Restraint Review Committee. Each hospital or nonhospital facility shall have a Restraint Review Committee. The members of the committee shall be appointed by the health care supervisor and shall consist of five members; two from facility staff and three community persons who are knowledgeable in the field of mental health. A quorum shall consist of three members. The committee may be one formed specifically for the purposes set forth in this rule, or the duties prescribed in this rule may be assigned to an existing committee. The purpose and duty of the Restraint Review Committee is to review and evaluate, at least quarterly, the appropriateness of all such interventions and report its findings to the health care supervisor.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0040

309-033-0740
Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0050

Standards for the Denial of Payment for Services to Persons in Custody or on Diversion

309-033-0800
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for the denial of payment for persons in custody or on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.241(5)(c) and 430.041 and carry out the provisions of ORS 426.241.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats Implemented: ORS 426.241
Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0000

309-033-0810
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "Community hospital" means any hospital that is not a state hospital.

(5) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(6) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(7) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(8) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(9) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(10) "Psychologist" means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.241

Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0010

309-033-0820
Denial of Payment for Services to Persons In Custody or On Diversion

(1) Assistant Administrator denial. The Assistant Administrator shall deny part or all payment for services for a person in custody or on a diversion only when the Assistant Administrator determines that evidence required by OAR 309-033-0820(3), Information Payer Must Submit, and the evidence required by OAR 309-033-0820(4), Clinical Records to be Submitted, does not reasonably support the belief that the person in custody demonstrated:

(a) Mental illness; and

(b) Dangerousness to self or others as evidenced by thoughts, plans, means, actions, history of dangerousness or other indicators of imminent dangerousness which Division believes are within accepted community standards of professional knowledge.

(2) Assistant Administrator consultation with psychiatrist or psychologist. When making a determination under this rule which is primarily based on accepted community standards of professional knowledge, the Assistant Administrator shall consult with a psychiatrist or a psychologist.

(3) Information payer must submit. When making a request for denial of payment the payer responsible for the services provided to the person in custody or on diversion under ORS 426.241 shall submit the following to the Assistant Administrator:

(a) A statement requesting the Division review the appropriateness of the hold or diversion for the purpose of approving denial of part or all payment for services rendered.

(b) An explanation of why the payer believes the services provided to the person in custody or on diversion do not meet criteria described in ORS 426.232(1), 426.233(1) or 426.237.

(c) Any documentation which supports the payer's belief that the services provided to the person in custody or on diversion were inappropriate.

(4) Clinical records to be submitted. At the request of the Division, as provided by ORS 426.241(5)(b), the following shall submit clinical records and other documents requested relating to the services in question to the Division:

(a) A hospital or a nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion.

(b) A physician or person providing services to the person in custody or on diversion.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.241
Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0030

309-033-0830
Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.241
Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0040

Standards for the Investigation and Examination of a Person Alleged to be a Mentally Ill Person

309-033-0900
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures relating to the investigation and examination of a person alleged to be a mentally ill person during the involuntary civil commitment process.

(2) Statutory authority. These rules are authorized by ORS 426.060, 426.072(3), 426.075, 426.110(2), 426.120, 426.140(2), 426.170, 426.180, 426.217, 426.220, 426.225, 426.228, 426.231, 426.232, 426.233, 426.236, 426.241(5), 426.495, 426.500, 430.041, and 430.205 through 430.210 and carry out the provisions of ORS 426.005 through 426.309.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0000

309-033-0910
Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or designee.

(2) "Assistant Administrator" means the Assistant Administrator of the Office of Mental Health Services of the Division.

(3) "Clinical record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community hospital" means any hospital that is not a state hospital.

(6) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(7) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) "Designee" means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) "Director" means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. "Director" also means a person who has been authorized by the director to act in the director's capacity for the purpose of this rule. In the case of the direc-

tor ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(12) "NMI" is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(13) "Peace officer" means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(14) "Psychiatrist" means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(15) "QMHP" means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0010

309-033-0920
Certification of Mental Health Investigators

(1) Investigation only by a certified investigator. Only a person certified by the Division shall conduct an investigation of a person alleged to be a mentally ill person as required by ORS 426.070(3)(c) and 426.074.

(2) Certification of a mental health investigator. The Division shall certify as a qualified mental health investigator, for three years or until such time as the Division terminates the certificate, any person who meets the following:

(a) Is recommended by a director for certification as a mental health investigator; and

(b) Is a QMHP, or on January 1, 1988, has been employed by a CMHP as an investigator for a minimum of two years; and

(c) Has established individual competence through training provided by the Division and within 6 months of the training has passed an examination conducted by the Division in the following areas:

(A) The role and duties of an investigator and the process of investigation;

(B) Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons;

(C) Establishing probable cause for mental disorder;

(D) The mental status examination; and

(E) The assessment of suicidality, assaultiveness, homocidality and inability to care for basic needs.

(3) Certification of a senior mental health investigator. The Division shall certify as a senior mental health investigator, for five years or until such time as the Division terminates the certificate, a person who meets the following:

(a) Is recommended by a director for certification as a senior mental health investigator;

(b) Is a QMHP;

(c) Has been certified as a mental health investigator for three years; and

(d) Has completed the training required under OAR 309-033-0920(2)(c) during the six months prior to application for certification.

(4) Certification of a mental health investigator resident. The Division shall certify as a mental health investigator resident for a nonrenewable period of six months, or until such time as the Division terminates the certificate, a person who meets the following:

(a) Is recommended by a director for certification as a mental health investigator;

(b) Is a QMHP;

(c) Has passed an examination conducted by the Division regarding Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons; and

(d) Is supervised by a certified senior mental health investigator. The senior mental health investigator shall review each investigation conducted by the mental health investigator resident and co-sign each investigation report as evidence that the senior mental health investigator believes the report meets OAR 309-033-0940, The Investigation Report.

(5) Qualifications for recertification. The Division may recertify a mental health investigator or a senior mental health investigator who is currently employed by a CMHP, is recommended by the director for recertification and who, during the period of certification, has completed eight hours of training or education in the assessment of mental disorder or the assessment of dangerousness which is approved by the Division.

(6) Residents cannot be recertified. The Division shall not recertify a mental health investigator resident.

(7) Termination of certification. The Division may terminate the certification of a mental health investigator, senior mental health investigator, or a mental health investigator resident when, in the opinion of the assistant administrator:

(a) The person no longer can competently perform the duties required by this rule, or

(b) The person has exhibited a behavior or a pattern of behavior which violates the rights, afforded by statute, of persons being investigated.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0030

309-033-0930
Investigation of Person Alleged to Be a Mentally Ill Person

(1) Initiation and timelines for investigation. Upon receipt of an NMI the CMHP shall conduct an investigation of the person to determine probable cause for mental disorder. The person conducting the investigation shall not be the same as the person filing the NMI.

(a) Investigation of NMIs by two persons, a county health officer or a magistrate. At a minimum, if the person can be located, the investigator must contact the person by telephone within three judicial days of the receipt of the NMI by the director.

(A) The investigator shall complete an investigation and submit an investigation report to the circuit court within 15 days of the director's receipt of the NMI.

(B) The investigator may request an extension from the court if a treatment option less-restrictive than involuntary inpatient commitment is actively being pursued or if the person cannot be located.

(b) Investigation of persons in custody. The investigator shall investigate persons in custody in an approved hospital under ORS 426.232 or 426.2033 as soon as reasonably possible but no later than one judicial day after the initiation of the detention and 24-hours prior to the hearing. Whenever feasible, the investigator shall:

(A) Make face-to-face contact with the person within 24 hours of admission to a hospital or nonhospital facility, including weekends; and

(B) Meet with the person one additional time prior to making a recommendation for the court to hold a commitment hearing.

(2) Procedures for the investigation. Only certified mental health investigators, senior mental health investigators or mental health investigator residents shall conduct an investigation of a person.

(a) While conducting an investigation, the investigator shall:

(A) Present photo identification, authorized and provided by the county mental health authority, to the person; and

(B) Explain the reason for the investigation orally and, if doing so would not endanger the investigator, in writing.

(b) Information from relatives. The investigator shall solicit information about the person from person's parents and relatives, whenever feasible.

(c) Disclosure of names. The investigator shall disclose the names of the persons filing the NMI to the allegedly mentally ill person except when, in the opinion of the investigator, disclosure will jeopardize the safety of the persons filing the NMI. The investigator may withhold any information that is used in the investigation report, only until the investigation report is delivered to the court and others as required under ORS 426.074(3). The investigator may withhold any information that is not included in the investigation report if the investigator determines that release of the information would constitute a clear and immediate danger to any person (see ORS 426.370).

(d) Encourage voluntary services. The director shall attempt, as appropriate, to voluntarily enroll in the least restrictive community mental health services a person for whom an NMI has been filed.

(e) Clinical record required. The director shall maintain a clinical record for every person investigated under this rule. The clinical record shall document to the extent possible the following:

(A) A brief summary of the events leading to the filing of an NMI, the circumstances and events surrounding the interview of the person and the investigator's attempts to engage the person in voluntary mental health services;

(B) Identifying information about the person;

(C) A copy of the NMI;

(D) A copy of the investigation report submitted to the court;

(E) Names, addresses and telephone numbers of family, friends, relatives or other persons who the investigator interviewed for pertinent information. This list shall include the names of the persons filing the NMI with the director; and

(F) Summary of the disposition of the case.

(f) Coordination of services. In the event the person is released or agrees to voluntary treatment, the investigator shall coordinate with the CMHP for the purpose of referral and offering voluntary treatment services to the person as soon as reasonably possible.

(3) Access to clinical records. The investigator shall have access to clinical records of the person being investigated as follows:

(a) When the person is in custody. The investigator shall have access only to clinical records compiled during the hold period. Without valid consent, the investigator shall not have access to clinical records compiled as part of treatment that is provided to the person at any time outside the hold period except as provided by OAR 309-033-0930(3)(b).

(b) When the person investigated is eligible for commitment pursuant to ORS 426.005(1)(d)(C). The investigator shall have access to any clinical record necessary to verify the existence of the criteria which make the person eligible for commitment pursuant to ORS 426.005(1)(d)(C).

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0040

309-033-0940
The Investigation Report

(1) Evidence required in report. The investigator shall include in a report to the court, if relevant or available, evidence and the source of that evidence in the following areas:

(a) Evidence which describes the present illness and the course of events which led to the filing of the NMI and which occurred during the investigation of the person.

(b) Evidence to support or contradict the allegation that the person has a mental disorder.

(c) Evidence to support or contradict the allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety.

(2) Documentation of manifestation of mental disorder. The evidence which describes the present illness shall include:

(a) The situation in which the person was found and the most recent behaviors displayed by the person which lead to and support the filing of an NMI;

(b) The sequence of events affecting the person during the investigation period including dates of admission, transfer or discharge from a hospital or nonhospital facility;

(c) Any change in the mental status of the person during the course of the investigation; and

(d) Attempts by the investigator to engage the person in voluntary treatment in lieu of civil commitment and their outcome.

(3) Documentation of mental disorder. Evidence to support or contradict the allegation that the person has a mental disorder shall include the results of a mental status examination and a psychosocial history.

(a) Mental status examination. A mental status examination shall review the presence of indicators of mental disorder in the following areas:

(A) Appearance. Features of the person's dress, physical condition which may indicate the presence of a mental disorder.

(B) Behavior. Features of the person's behavior, movement or rate of speech which may indicate the presence of mental disorder.

(C) Thought content. Features of the content of the person's speech such as delusions and hallucinations which may indicate the presence of a mental disorder.

(D) Thought process. Features of the person's expressed thoughts which may indicate that the person is unable to think in a clear logical fashion and which may indicate the presence of a mental disorder.

(E) Insight. Features of the person's understanding of his/her current mental state which may indicate the presence of a mental disorder.

(F) Judgment. Features of the person's judgment about social situations and dangerous situations which may indicate the presence of a mental disorder.

(G) Cognitive testing. Features of the person's ability to concentrate, ability to remember recent and historical events, ability to use abstract thinking, and ability to use or remember generally known information which may indicate the presence of a mental disorder.

(H) Emotions. Features of the person's emotions, such as being inappropriate to the situation, which may indicate the presence of a mental disorder.

(b) Psychosocial History. A psychosocial history shall discuss the presence of indicators of mental disorder in the following areas:

(A) Psychiatric history.

(i) History of psychiatric or mental health treatment;

(ii) History of commitments for mental disorder including verification from the Division if available; and

(iii) Current participation in mental health treatment.

(B) Family history.

(i) Members of the person's family who have a history of psychiatric or mental health treatment;

(ii) Members of the person's family who have a history of commitment for mental disorder; or

(iii) Reports of family members who appear to have had an untreated mental disorder.

(C) History of alcohol or drug abuse.

(i) History of abusing alcohol or drugs;

(ii) Behaviors which the person may have displayed during the course of the investigation, which are substantially similar to behaviors that indicate the presence of a mental disorder, that may be attributable to the use of alcohol or drugs; or

(iii) If the person appears to have a mental disorder, the effect of the person's current use of alcohol or drugs on behaviors that may indicate the presence of a mental disorder.

(D) History of a loss of function.

(E) Social function.

(F) Personal finances.

(i) Availability of financial resources to provide for basic needs such as food and shelter;

(ii) Use of financial resources to meet needs for food and shelter; or

(iii) Other features of the manner in which the person uses money which would indicate the presence of a mental disorder.

(G) Medical issues.

(i) Medical conditions that may produce behaviors which are substantially similar to behaviors that indicate the presence of a mental disorder; or

(ii) Medical conditions which contribute to the seriousness of a mental disorder which appears to be present.

(4) Documentation of dangerousness and/or inability to provide for basic needs. Evidence to support or contradict the allegation that the person is a danger to self or others, or is unable to provide for basic

personal needs and is not receiving such care as is necessary for health and safety shall include the results of an assessment of dangerousness.

(a) An assessment of dangerousness to self shall consider the following areas:

(A) History of thoughts, plans or attempts at suicide;

(B) Presence of thoughts, plans or attempts at suicide;

(C) Means and ability to carry out the plans for suicide;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at suicide; and

(F) Available support systems which may prevent the person from acting on the plan.

(b) An assessment of dangerousness to others shall consider the following areas:

(A) History of thoughts, plans, attempts or acts of assaultiveness or violence;

(B) Presence of thoughts, plans, attempts or acts of assaultiveness or violence;

(C) Means and ability to carry out the plans for assaultiveness or violence;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at assault or violence; and

(F) Available support systems which may prevent the person from attempting an assault or an act of violence.

(c) An assessment of the person's ability to provide for basic personal needs shall consider the following areas:

(A) History of the person's ability to provide for basic personal needs;

(B) The person's current use of resources to obtain food, shelter, and health care necessary for health and safety;

(C) Behaviors which result in exposure to danger to self or others;

(D) Available support systems which may provide the person care necessary for health and safety; and

(E) If the person appears to lack capacity to care for self, the availability of a guardian who can assure the provision of such care.

(5) Additional report requirements. The investigation report shall also include the following:

(a) The person's consent or objection to contact with specific third parties.

(b) If appropriate and if available from the Division, verification of the person's eligibility for commitment under ORS 426.005(c).

(6) Report availability. The investigation report shall be made available to the facility with custody of the person if the person is committed.

(7) Investigator's responsibilities to the circuit court. The investigator shall file the investigation report with the circuit court twenty-four hours before the hearing and shall appear at the civil commitment hearing.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0050

309-033-0950
Certification of Mental Health Examiners

(1) Psychiatrists exempt from certification. A psychiatrist may serve as an examiner as provided by ORS 426.110(2)(b)(A). Division certification is not necessary for psychiatrists serving as mental health examiners.

(2) Qualifications for certification of persons other than psychiatrists. The Division shall certify, as a qualified mental health examiner for three years or until such time as the Division terminates the certificate, a QMHP who meets all of the following:

(a) Has at least three years clinical experience in the diagnosis and treatment of severely mentally ill adults who suffer primarily from a psychotic disorder;

(b) Presents acceptable written references from two persons who have the above qualifications and can demonstrate direct knowledge of the person's qualifications;

(c) Is recommended by the director to be an examiner in the county; and

(d) Has established individual competence through training provided by the Division in the following areas:

(A) The role and duties of an examiner and the process of examination;

(B) Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons;

(C) Establishing clear and convincing evidence for mental disorder;

(D) The mental status examination; and

(E) The assessment of suicidality, assaultiveness, homocidality and inability to care for basic needs.

(3) Qualifications for recertification. The Division may recertify for three years, or until such time as the Division terminates the certificate of, any mental health examiner who meets the following:

(a) The examiner has been an examiner certified by the Division after July 1, 1988;

(b) The examiner has successfully completed eight hours of training provided by the Division relating to the assessment and diagnosis of mental disorder and, changes in statutes and administrative rules relating to civil commitment; and

(c) The director recommends the person to be an examiner in the county.

(4) Examination. The examiner shall conduct an examination in a manner that elicits the data necessary for establishing a diagnosis and a plan for treatment. Only certified examiners shall conduct an examination of an allegedly mentally ill person.

(5) Termination of certification. The Division may terminate the certification of any mental health examiner when, in the opinion of the assistant administrator:

(a) The person no longer can competently perform the duties required by this rule; or

(b) The person has exhibited a behavior or a pattern of behavior which violates the rights, afforded by statute, of persons being investigated.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0060

309-033-0960
Mental Health Examiner's Report to the Court

(1) Examiner assessment of evidence. The examiner shall provide in a report to the court the examiner's opinion whether the evidence supports or contradicts:

(a) The allegation that the person has a mental disorder;

(b) The allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety; and

(c) That the person would cooperate with and benefit from voluntary treatment.

(2) Mental status examination and psychosocial history. In addition to considering other evidence presented at the hearing, the examiner shall conduct a mental status examination and a psychosocial history to determine whether the person alleged to be mentally ill has a mental disorder.

(a) Mental status examination. A mental status examination shall include review of the presence of indicators of mental disorder in the following areas:

(A) Appearance. Features of the person's dress, physical condition which may indicate the presence of a mental disorder.

(B) Behavior. Features of the person's behavior, movement or rate of speech which may indicate the presence of mental disorder.

(C) Thought content. Features of the content of the person's speech such as delusions and hallucinations which may indicate the presence of a mental disorder.

(D) Thought process. Features of the person's expressed thoughts which may indicate that the person is unable to think in a clear logical fashion and which may indicate the presence of a mental disorder.

(E) Insight. Features of the person's understanding of his/her current mental state which may indicate the presence of a mental disorder.

(F) Judgment. Features of the person's judgment about social situations and dangerous situations which may indicate the presence of a mental disorder.

(G) Cognitive testing. Features of the person's ability to concentrate, ability to remember recent and historical events, ability to use abstract thinking, and ability to use or remember generally known information which may indicate the presence of a mental disorder.

(H) Emotions. Features of the person's emotions, such as being inappropriate to the situation, which may indicate the presence of a mental disorder.

(b) Psychosocial history. A psychosocial history shall consider the presence of indicators of mental disorder in the following areas:

(A) Psychiatric history.

(i) History of psychiatric or mental health treatment;

(ii) History of commitments for mental disorder including verification from the Division if available; and

(iii) Current participation in mental health treatment.

(B) Family history.

(i) Members of the person's family who have a history of psychiatric or mental health treatment;

(ii) Members of the person's family who have a history of commitment for mental disorder; or

(iii) Reports of family members who appear to have had an untreated mental disorder.

(C) History of alcohol or drug abuse.

(i) History of abusing alcohol or drugs;

(ii) Behaviors the person may have displayed during the course of the investigation which are substantially similar to behaviors that indicate the presence of a mental disorder that may be attributable to the use of alcohol or drugs; or

(iii) If the person appears to have a mental disorder, the effect of the person's current use of alcohol or drugs on behaviors that may indicate the presence of a mental disorder.

(D) History of a loss of function.

(E) Social function.

(F) Personal finances.

(i) Availability of financial resources to provide for basic needs such as food and shelter;

(ii) Use of financial resources to meet needs for food and shelter; and

(iii) Other features of the manner in which the person uses money which would indicate the presence of a mental disorder.

(G) Medical issues.

(i) Medical conditions that may produce behaviors which are substantially similar to behaviors that indicate the presence of a mental disorder; or

(ii) Medical conditions which contribute to the seriousness of a mental disorder which appears to be present.

(3) Assessment of dangerousness and ability to provide basic needs. In addition to considering other evidence presented at the hearing, the examiner shall conduct an assessment of the danger the person represents to self or others and an assessment of the person's ability to provide for basic personal needs.

(a) An assessment of dangerousness to self shall consider the following areas:

(A) History of thoughts, plans or attempts at suicide;

(B) Presence of thoughts, plans or attempts at suicide;

(C) Means and ability to carry out the plans for suicide;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at suicide; and

(F) Available support systems which may prevent the person from acting on the plan.

(b) An assessment of dangerousness to others shall consider the following areas:

(A) History of thoughts, plans, attempts or acts of assaultiveness or violence;

(B) Presence of thoughts, plans, attempts or acts of assaultiveness or violence;

(C) Means and ability to carry out the plans for assaultiveness or violence;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at assault or violence; and

(F) Available support systems which may prevent the person from attempting an assault or an act of violence.

(c) An assessment of the person's ability to provide for basic personal needs shall consider the following areas:

(A) History of the person's ability to provide for basic personal needs;

(B) The person's current use of resources to obtain food, shelter, and health care necessary for health and safety;

(C) Behaviors which result in exposure to danger to self or other;

(D) Available support systems which may provide the person care necessary for health and safety; and

(E) If the person appears to lack capacity to care for self, the availability of a guardian who can assure the provision of such care.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0070

309-033-0970
Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Office of Mental Health Services review. The Assistant Administrator or designee of the Office shall approve or deny the request for a variance.

(4) Notification. The Office shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.060 - 426.500 & 430.041
Stats. Implemented: ORS 426.005 - 426.309
Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0080

DIVISION 34

OTHER CONTRACT SERVICES

Medicaid Payment for Child/Adolescent Residential Psychiatric Treatment Services

309-034-0150
Purpose and Statutory Authority

(1) Purpose. These rules describe the methods and standards for payments for psychiatric residential treatment facilities for the provision of community psychiatric residential treatment services for children eligible for medical assistance under Medicaid (Title XIX of the Social Security Act). Psychiatric residential treatment services are provided within a comprehensive system of care and are provided to children whose treatment history, degree of impairment, current symptoms and degree of family and other supports require this level of care.

(2) Statutory Authority. These rules are authorized by ORS 430.705 and 430.715 and carry out the provisions of ORS 414.025, 414.065, and 414.085.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0160
Definitions

(1) "Active Treatment" means of a professionally developed and supervised individual plan of care to improve a condition.

(2) "Allowable Cost." The cost of psychiatric residential treatment services based on cost finding principles found in "Cost Principles for Non-Profit Organization" (OMB Circular A-122) and includ-

ing costs incurred for interest on the acquisition of buildings and improvements thereon.

(3) "Certification of Need." Procedures established by the Mental Health and Developmental Disability Services Division (MHDDSD) to certify in writing a child's need for psychiatric residential treatment services.

(4) "Child" or "Children" means a person or persons under the age of 18, or for those with Medicaid eligibility under the age of 21.

(5) "Commission on Accreditation of Rehabilitation (CARF)." An organization that accredits behavioral health care and community providers based on the current edition of the "CARF Behavioral Health" standards manual.

(6) "Council on Accreditation of Services for Families and Children Facilities (COA)." An organization that accredits behavioral health care and social service programs based on the current edition of the COA "Standards for Behavioral Health Care Services and Community Support and Education Services Manual."

(7) "Direction of the psychiatrist" means medical oversight of the clinical aspects of care required of accredited "inpatient under 21" providers by the Health Care Financing Administration (HCFA). Medical oversight includes participation on the interdisciplinary team, prescribing treatment on individual plans of care by signature, prescribing and/or monitoring medications and reviewing special treatment procedures."

(8) "Division." The Mental Health and Developmental Disability Services Division (MHDDSD) of the Department of Human Services.

(9) "DSM" means the most current edition of the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.

(10) "Individual Plan of Care" means the written plan authored by a Qualified Mental Health Professional for active treatment for each child admitted for psychiatric residential treatment services. The individual plan of care specifies the DSM diagnosis, goals, measurable objectives, and specific treatment modalities and is based on a completed mental health assessment or comprehensive mental health assessment of the child's functioning and the acuity and severity of psychiatric symptoms.

(11) "Interdisciplinary Team" means a team of qualified treatment and education professionals including a child psychiatrist or Licensed Medical Practitioner and the child's parent or guardian responsible for assessment and evaluation, the development and oversight of individual plans of care, and the provision of treatment for children admitted to an intensive treatment services program.

(12) "JCAHO." Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission accredits psychiatric residential treatment facilities according to its current edition of the "Comprehensive Accreditation Manual for Behavioral Health Care."

(13) "Maximum Per Diem Payment." The established payment rate determined by the Division, based on a cost model for an economic and efficiently operated facility.

(14) "Medicaid" means the federal grant-in-aid program to state governments to provide medical assistance to poor and indigent persons under Title XIX of the Social Security Act.

(15) "Medicaid Patient Days." The accumulated total number of days during which psychiatric residential treatment services were provided to Medicaid-eligible children during a contract period. The Division shall determine the total number of Medicaid patient days on the basis of dates of service per patient by provider and fiscal period.

(16) "Psychiatric Residential Treatment Facility." A facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the Commission on Accreditation of Rehabilitation (CARF); the Council on Accreditation of Services for Families and Children (COA); or any other accrediting organization, with comparable standards, that is recognized by the State. The facility must also be licensed by the State Office for Services to Children and Families (SOSCF) for treatment of children under age 21.

(17) "Psychiatric Residential Treatment Services" means the services provided by nationally accredited providers certified under these rules for children who require active psychiatric treatment for a diagnosed mental disorder in a 24-hour residential setting.

(18) "State Office for Services to Children and Families (SOSCF)" means the Division serving as Oregon's child welfare agency.

(19) "System of care" means the comprehensive array of mental health and other necessary services which are organized to meet the multiple and changing needs of children with severe emotional disorders and their families.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430.705 & 430.715

Stats. Implemented: ORS 414.025, 414.065 & 414.085

Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0170
Conditions of Service Provider Participation

Service provider must:

(1) Submit a completed application packet to the Division. No billing for Medicaid payment will be made until the service provider has received written approval from the Division.

(2) Provide psychiatric residential treatment services to children eligible for Medicaid benefits under the terms of a written agreement with the Division. The agreement must require that the psychiatric residential treatment facility and the services provided comply with all applicable state and federal requirements.

(3) Be in compliance with the applicable State and Federal Civil Rights Laws.

(4) Support and protect the fundamental human, civil, constitutional, and statutory rights of each child.

(5) Be accredited as a psychiatric residential treatment facility for children under age 21 by JCAHO, CARF, COA, or any other accrediting organization, with comparable standards, that is recognized by the State; be licensed by SOSCF; hold a Certificate of Approval per OAR 309-012-0130 through 309-012-0220 from the Division and be in compliance with the treatment services standards described in OAR 309-032-1100 through 309-032-1230.

(6) Provide a program consistent with standards set by JCAHO, CARF, COA, or any other accrediting organization, with comparable standards, that is recognized by the State.

(7) Keep fiscal records in accordance with generally accepted accounting principles.

(8) Keep detailed clinical records on each child verifying the need for psychiatric residential treatment services, as documented by the diagnosis and assessment, individualized plans of care, and services rendered.

(9) Make available to the Division or its authorized representatives, financial and treatment records including mental health, dental, dietetic, pastoral, pharmacy, emergency, and general medical services.

(10) Provide a physical facility suitable for treatment of children with attention to proper safety and sanitation, housekeeping, and general environment. Buildings shall comply with all applicable building, occupancy, electrical, plumbing, and zoning codes.

(11) Obtain certification for the admission of children to the psychiatric residential treatment facility following the Division's Certification of Need procedures.

(12) Accept payment from the Division as full and total payment for the Medicaid services provided.

Stat. Auth.: ORS 430.705 & 430.715

Stats. Implemented: ORS 414.025, 414.065 & 414.085

Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0180
Eligibility and Admission Policy

(1) In considering a child for admission for psychiatric residential treatment services, Certification of Need procedures will certify that:

(a) Other treatment resources available in the community do not meet the treatment needs of the child;

(b) Proper treatment of the child's psychiatric condition requires services on a psychiatric residential treatment basis under the direction of a psychiatrist;

(c) The services can reasonably be expected to improve the child's condition or prevent further regression so that psychiatric residential treatment services may no longer be needed; and

(d) The child has a principal diagnosis on Axis I of a completed 5-Axes DSM diagnosis that is not solely a result of mental retardation

or other developmental disabilities, epilepsy, drug abuse, or alcoholism.

(2) The child must be eligible for medical assistance under Medicaid, according to procedures established by the Division, and meet the criteria for admission to psychiatric residential treatment services as defined by these rules.

(3) The Division shall authorize payment for psychiatric residential treatment services for children upon certification of need by the Division.

(4) If a Medicaid applicant's or recipient's certification for psychiatric residential treatment services is denied or terminated, the applicant or recipient has the right to request a fair hearing in accordance with ORS Chapter 183.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0190
Admission Procedures Related to Payment

(1) Admission procedures for children eligible for Medicaid will be reviewed through an independent psychiatric review process established by the Division to certify the need for services.

(2) The referring source or the facility will make available for certificate of need for services process the following information about the referred child:

(a) A written psychological and/or psychiatric evaluation completed within the previous 60 days;

(b) A written psychosocial history following the format required by the admission procedure of the facility to which the child has been referred;

(c) Results of any direct patient observation and assessment of the child subsequent to the referral; and

(d) Other information from the referral source, other involved community agencies, and the family, that are pertinent and appropriate to the admission procedure.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0205
Levels of Care Criteria

Children shall be served in the least restrictive, least intensive setting appropriate to their treatment history, degree of impairment, current symptoms and the extent of family and other supports. The provider must recommend the appropriate level of care to the child and parent or guardian when a more restrictive or less restrictive level of care is determined to be medically necessary.

(1) The following criteria are used to determine the appropriateness of continued stay:

(a) The child is making observed progress toward identified treatment goals as documented in the individual plan care, but the measurable treatment objectives necessary to reach the goals have not been completed;

(b) The child made no documented progress toward treatment goals, but the individual plan care and measurable objectives necessary to reach the goals have been reviewed by the psychiatrist and modified in order to reevaluate the child's treatment needs, clarify the nature of the identified problems, and/or initiate new therapeutic interventions; or

(c) The child exhibits new symptoms or maladaptive behaviors that justify continuation and can be safely and effectively treated at a community-based residential level of care. The individual plan care has been revised accordingly.

(2) A planned discharge will occur when the following criteria are met:

(a) The child's targeted symptoms and maladaptive behaviors have abated to an established baseline level as documented by the attainment of specific goals and measurable objectives in the treatment plan; or

(b) The child exhibits new symptoms and maladaptive behaviors which may not be safely or effectively treated at this level of care; or

(c) The child is not benefiting from treatment and made no progress toward specific treatment goals or measurable objectives in the last 90 day seven though appropriate treatment plan reviews and revisions were conducted.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0210
Rate Setting

In order to establish the maximum allowable payment amount, the Division will use a per diem payment rate based on a cost model determined by the State of Oregon to represent 100% of the reasonable costs of an economically and efficiently operated facility.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96

309-034-0240
Billing Requirements

(1) Bills shall be submitted on a monthly basis to the Division, through the Office of Medical Assistance Programs (OMAP), on forms designated by the Division. Payment shall not be made for services which were provided more than 12 months prior to presentation of the claim unless the facility shows that the delay was caused by factors outside its control.

(2) Billings must be based upon the lower of:

(a) The reasonable and allowable costs of services in accordance with OMB Circular A-122 or other applicable state and federal laws, rules and regulations; or

(b) The maximum per diem payment rate as provided in OAR 309-034-0210.

(3) Billing to the Division shall in no case exceed the customary charges to privately funded children for any like item or service charged by the facility.

(4) A provider must pursue third-party payments from Social Security, health insurance or other sources that may cover services provided to enrolled children. Any such payments received must be indicated on billings to OMAP and used to offset the cost of providing psychiatric residential treatment services.

(5) Any payment received by the facility prior to the submission of the invoice to the Division shall be indicated as a credit on the invoice.

(6) Any payments to the provider for services provided to an eligible patient from any source subsequent to payment by the Division shall be reported on an adjustment request form, giving full details. Failure to report such payments will be considered concealment of material facts and is grounds for recovery and/or sanction.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0250
Payments

(1) Payments will be made for the provision of active psychiatric residential treatment services on a filled-bed basis, including approved leave for children eligible for such services under Medicaid. If active treatment is not documented during any period in which Division payments are made on behalf of a child, the Division may recoup such payments.

(2) The Division will pay for the day of admission but not for the day of discharge.

(3) Title XIX eligible children receiving psychiatric residential treatment services will be subject to periodic review by a professional review organization to determine medical appropriateness and quality of services. If a review reveals that a child received an inappropriate level of care, i.e., less than active treatment, payment will not be allowed under these rules.

(4) Payment by the Division constitutes payment in full for psychiatric residential treatment services. The rate established for a facility includes payment for all services, supplies, and facility equipment

required for care, by State and Federal standards except for medical care or services by outside providers paid separately through other Title XIX Medical Assistance funds, Title XVI, Veterans Administration, etc.

(5) Payment for planned absences from the program such as home care visits, and transitions shall be allowed if the absences are:

(a) Based on the individual clinical needs of the child; and

(b) Specified in the child's individual plan of care's measurable objectives and/or discharge plan; and

(c) Documented in progress notes; and

(d) The duration of any single planned absence is no more than seven consecutive days, unless a longer duration is authorized in writing by the Division.

(6) Payment for unplanned absences from the program such as runaway, hospitalization, and detention shall be allowed if;

(a) The provider clearly documents in the child's clinical record regular and ongoing case coordination efforts undertaken by the program during the unplanned absence; and

(b) The provider clearly documents in the child's clinical record that the child will be returned to the program when the unplanned absence is resolved; and

(c) The duration of any single unplanned absence is no more than seven consecutive days, unless longer duration is authorized in writing by the Division.

(7) Payment for unplanned absences from the program shall be disallowed if the child is not returned to the program, unless the interdisciplinary team, in consultation with the child's parent(s) or guardian or provider of the next level of care determines that the child requires a more or less restrictive level of care.

(8) Planned absences from the program which are not indicated in the child's individual plan of care and/or discharge plan shall be considered unplanned absences and payment will be disallowed.

(9) An additional five day per contracted bed per year may be used an unfilled vacant bed days. The use of these vacancy days will be determined by the psychiatric residential treatment facility. The Division will track utilization through the computerized billing system and make annual contract settlements accordingly.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0260
Allowable and Non-Allowable Costs

(1) Costs of a Psychiatric Residential Treatment Facility will be subject, but not limited to the allowable and non-allowable costs as determined by cost finding principles found in "Cost Principles for a Non-Profit Organization" (OMB Circular A-122) with the exception of interest: Mortgage interest on the acquisition of buildings and improvements, which is necessary and proper, will be classified as an allowable cost for a non-profit psychiatric residential treatment facility:

(a) "Necessary" requires that the interest be incurred on a loan made for a purpose reasonably related to patient care.

(b) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(2) In accord with the Deficit Reduction Act of 1984, as outlined in the Social Security Act, Section 1851(V)(I)(O), for determining the allowance for depreciation and interest on capital indebtedness with respect to a non-profit psychiatric residential treatment facility which has undergone a change of ownership, this rule provides that the valuation of the asset after such a change of ownership has occurred shall be the lesser of the allowable acquisition cost of such an asset to the owner of record as of July 18, 1984, or the acquisition cost of such an asset to the new owner. In the case where the asset was in existence prior to July 18, 1984, the value of the asset will be based on the allowable acquisition cost to the first owner of record after July 18, 1984, thereby eliminating upward revaluation of an asset. The recapture of depreciation only up to the full value of the initial asset is allowed.

(3) Non-allowable costs include but are not limited to:

(a) Educational program services as defined by the Department of Education.

(b) Costs of services otherwise reimbursed through OMAP medical programs.

(c) Costs (including legal fees, accounting and administrative costs, travel costs, and costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97; MHD 4-2001, f. 7-3-01, cert. ef. 7-5-01

309-034-0270
Accounting and Record Keeping

(1) The provider shall maintain, for a period of not less than three years following the date of submission of billings to OMAP, the financial and statistical records which are accurate and in sufficient detail to substantiate the billings. If there are audit issues, the records must be maintained for three years after the audit settlement. The records shall be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules.

(2) Expenses reported as allowable costs must be adequately documented in the financial records of the provider, or they shall be disallowed in an audit.

(3) Each provider is required to notify the Division in writing within 30 days of the effective date of a change in ownership.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97

309-034-0290
Auditing

(1) Provider billings are subject to review by the Division.

(2) The scope of the review will verify, to the extent possible, that the provider has properly billed only its allowable costs on the basis of generally accepted accounting principles, that the provider has properly applied the cost finding methods specified by the Division to its allowable costs, and whether the analysis indicates that further auditing of the provider's financial and statistical records is needed.

(3) If the Division determines an overpayment has been made to a provider, the amount of overpayment is subject to recovery by the Division in accordance with applicable state and federal laws, rules and regulations.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 7-1991(Temp), f. 8-30-91, cert. ef. 9-1-91; MHD 3-1992, f. 1-10-92, cert. ef. 1-13-92 (and corrected 1-31-92); MHD 4-1996, f. & cert. ef. 3-22-96; MHD 7-1996(Temp), f. & cert. ef. 10-1-96; MHD 4-1997, f. & cert. ef. 3-20-97

309-034-0310
Provider Appeals

(1) A provider who receives any of the following decisions may appeal to the Division:

(a) A denial or limitation of payment allowed for services or items provided;

(b) Overpayment determinations; or

(c) Sanctions imposed or intended to be imposed by the Division.

(2) Appeals must be in writing and postmarked no later than thirty days after receipt of the Division's notification.

(3) The provider may request an administrative review of a contested case hearing as set forth in the OMAP General Rules for Medicaid.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 4-1997, f. & cert. ef. 3-20-97

309-034-0320
Variance

A variance from those portions of these rules that are not derived from federal regulations or the OMAP General Rules may be granted for a period of up to one year in the following manner:

(1) The provider shall submit to the Assistant Administrator of the Office of Mental Health Services a written request which includes:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed; and

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(2) The Assistant Administrator of the Office of Mental Health Services shall approve or deny the request for variance in writing.

(3) The Office of Mental Health Services shall notify the provider of the decision in writing within 30 days of the receipt of the request.

(4) Appeal of the denial of a variance request shall be to the Administrator of the Division whose decision shall be final.

(5) All variances must be reapplied for annually.

Stat. Auth.: ORS 430.705 & 430.715
Stats. Implemented: ORS 414.025, 414.065 & 414.085
Hist.: MHD 4-1997, f. & cert. ef. 3-20-97

Licensed Children's Emergency Safety Intervention Specialist

309-034-0400
Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures relating to licensing Children's Emergency Safety Intervention Specialist. A licensed Children's Emergency Safety Intervention Specialist is authorized to order, monitor, and evaluate the use of personal restraint and seclusion in accredited and certified facilities providing psychiatric residential treatment services to individuals under 21 years of age. The Children's Emergency Safety Intervention Specialist license is for the purpose of licensing qualified mental health professionals (QMHP) who are not licensed by any other healthcare licensing board. It is not to be issued as an additional credential to currently licensed practitioners such as licensed clinical social workers, licensed registered nurses, licensed psychologists, licensed professional counselors, licensed marriage and family therapist, or licensed physicians.

(2) Statutory Authority. These rules are authorized by House Bill 2626 to carry out the provisions set forth in House Bill 2626.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0410
Definitions

As used in these rules:

(1) "Chemical Restraint" means any drug that:

(a) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

(b) Has the temporary effect of restricting the resident's freedom of movement; and

(c) Is not a standard treatment for the resident's medical or psychiatric condition.

(2) "Children's Emergency Safety Intervention Specialist" means a QMHP who is authorized to order, monitor, and evaluate the use of personal restraint and seclusion in accredited and certified facilities providing psychiatric residential treatment services to individual under 21 years of age.

(3) "Department" means the Department of Humans Services.

(4) "Emergency safety intervention" means the use of restraint or seclusion as an immediate response to an emergency safety situation.

(5) "Emergency Safety Intervention Training" means a Department approved course that teaches students to safely manage emergency safety situations and methods for reducing the need for emergency safety interventions. The minimum requirements for a Department approved course is one that has an established curriculum, includes an identified instructor, requires an identified number of face to face instruction hours, teaches students how to safely manage emergency safety situations, includes methods to de-escalate volatile clients, and has an evaluation component to assess the student's competency of the course materials.

(6) "Emergency safety situation" means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

(7) "Mechanical restraint" means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

(8) "Personal Restraint" means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.

(9) "Psychiatric Residential Treatment Services Provider" means an organization or agency accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation of Services for Families and Children (COA), or the Rehabilitation Accreditation Commission (CARF) and certified by the Department of Human Services to provide psychiatric residential treatment services for individuals under 21 years of age;

(10) "Qualified Mental Health Professional" or "QMHP" means a Licensed Medical Practitioner or any other person who meets the following minimum qualifications as documented by the provider:

(a) Holds any of the following educational degrees:

(A) Graduate degree in psychology;

(B) Bachelor's degree in nursing and licensed by the State of Oregon;

(C) Graduate degree in social work;

(D) Graduate degree in a behavioral science field;

(E) Graduate degree in recreational, music, or art therapy;

(F) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(b) Whose education and experience demonstrate the competency to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise an individual plan of care; conduct a Comprehensive Mental Health Assessment and provide individual, family and/or group therapy within the scope of their training.

(11) "Restraint" means a "personal restraint," "mechanical restraint," or "chemical" as defined in this section.

(12) "Seclusion" means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0420
Application for Licensure as a Children's Emergency Safety Intervention Specialist

In order to obtain a license as a Children's Emergency Safety Intervention Specialist, an agency that is certified by the Department of Human Services to provide psychiatric residential treatment services for individuals under 21 years shall make application on behalf of the licensure applicant. The Department shall issue a license as a Children's Emergency Safety Intervention Specialist to each applicant who furnishes satisfactory evidence to the Department that the applicant meets the following qualifications:

(1) Is employed by or providing services under contract with a provider that is certified by the Department of Human Services to provide psychiatric residential treatment services for individuals under 21 years of age;

(2) Meets qualifications established by the Department by rule for qualified mental health professionals;

(3) Has successfully completed an emergency safety intervention training program approved by the Department within the past 12 months;

(4) Demonstrates the ability to assess the psychological and physical well-being of individuals under 21 years of age;

(5) Demonstrates knowledge of federal and state rules governing the use of restraint and seclusion in intensive mental health treatment programs for individuals under 21 years of age.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0430
Scope of Licensure

(1) A licensed Children's Emergency Safety Intervention Specialist is authorized to:

(a) Order the least restrictive intervention, including personal restraint or seclusion that is most likely to be effective in resolving an emergency safety situation if the treatment team physician is not available.

(b) Provide the federally mandated face-to-face assessment of a child's well-being following and/or within one hour of the initiation of the emergency safety intervention; and

(c) Accept verbal orders for personal restraint and/or seclusion from a physician or licensed practitioner who is authorized to order personal restraint and seclusion.

(2) Exclusions to Licensure:

(a) A licensed Children's Emergency Intervention Specialist is not authorized to order or receive orders for the use of mechanical or chemical restraint.

(b) A Children's Emergency Safety Intervention Specialist license is only valid while the licensee is employed or contracting to provide services with the psychiatric residential treatment services program that submitted the application on behalf of the licensee.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0440
Application Process

(1) Application for licensure as a Children's Emergency Safety Intervention Specialist shall be made to the Department and be on forms provided by the Department.

(2) Application for licensure shall be accompanied by a formal written request from a provider that is certified by the Department of human Services to provide psychiatric residential treatment services for individuals under 21 years of age with which the applicant is employed or contracted. The request must include:

(a) Official transcript and supporting documentation as necessary showing the applicant meets qualifications established by rule for qualified mental health professional (QMHP);

(b) Verification that an emergency safety intervention course approved by the Department has been successfully completed within the past 12 months;

(c) Verification of certification in CPR and First Aid by a recognized training agency;

(d) A signed Criminal Record Clearance Check form as described in OAR chapter 407 division 007. The Criminal Record Check form will request information regarding criminal history and out-of-state residency;

(e) Verification of employment or contracted services with a provider that is certified by the Department of Human Services to provide psychiatric residential treatment services for individuals under 21 years of age;

(f) A copy of the completed examination or evaluation the provider used to determine the applicant's competence to assess the psychological and physical well being of individuals under 21 years of age; and

(g) A copy of the completed examination or evaluation the provider used to determine the applicants knowledge of the federal and state rules governing the use of restraint and seclusion in intensive mental health treatment programs for individuals under 21 years of age.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0450
Issuance of a License

(1) The Department shall issue a license within 30 days of the submission of a completed application. The license shall state the name of the licensee, the provider, and expiration date.

(2) The license shall be placed in the licensee's personnel file and be easily visible.

(3) An initial license is valid from the time of issuance until the expiration date, which will be September 30th of the following calendar year.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0460
Renewal and Expiration of License

(1) A license issued under these rules is subject to renewal every 2 years.

(a) All licenses will expire on September 30th. The issuance date of the licensee's first license will determine if the license expires on an odd or even year.

(b) At least 30 days prior to the expiration of a license, a reminder notice will be sent by the Department to the licensee and the provider.

(c) A licensee seeking renewal of a license shall have a provider with whom they are employed or contracted submit on their behalf:

(A) Proof of fulfillment of the following requirements;

(i) Verification of current certification in CPR and First aid by a recognized training agency;

(ii) A copy of the evaluation completed within the last year of the applicants competence to assess the psychological and physical well-being of individuals under 21 years of age.

(iii) A copy of the evaluation completed within the last year demonstrating the applicants knowledge of federal and state rules governing the use of restraint and seclusion in psychiatric residential treatment services programs for individuals under 21 years of age.

(B) Proof of continued employment or contract with a facility certified by the Department of Human Services to provide psychiatric residential treatment services for individuals under 21.

(2) A licensee may not continue to practice as a licensed Children's Emergency Safety Intervention Specialist after expiration of the license.

(3) A licensee may not continue to practice as a licensed Children's Emergency Safety Intervention Specialist upon discontinuation of employment or contract with the provider of psychiatric residential treatment services specified on the license.

(4) If the person's previous license has expired, the person must apply and qualify for a new license in the same manner as a person who has never been licensed.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0470
Complaint

(1) Any person who believes these rules have been violated may file a compliant with the Department.

(2) The Department shall establish a protocol for investigation of complaints and make that information available to anyone who files a complaint or has a complaint filed against them. Following the Departments investigation of a complaint, the Department may take action to:

(a) Dismiss the complaint;

(b) Issue a letter of reprimand;

(c) Direct the Provider to draft a plan of correction with the licensee; or

(d) Institute disciplinary action.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0480
Denial, Suspension, Revocation or Non-renewal of License

(1) The Department may deny, suspend, revoke or refuse to issue or to renew any license issued under these rules upon proof that the applicant for licensure or the licensee:

(a) Has been convicted of one or more crimes described in the Criminal Records Check OAR 407-007-0200 through 407-007-0380;

(b) Is unable to perform the duties of a Children's Emergency Safety Intervention Specialist by reason of mental illness, physical illness, drug addiction or alcohol abuse;

(c) Has been grossly negligent in the duties of a Children's Emergency Safety Intervention Specialist;

(d) Has violated one or more of the rules of the Department pertaining to the licensure of a Children's Emergency Safety Intervention Specialist;

(e) Has practiced outside the scope of activities for which the licensee has individual training and qualification; or

(f) Has been disciplined by a state licensing board or program in this or any other state for violation of competency or conduct standards.

(2)(a) The Department may reprimand or impose probation on a licensee upon proof of any of the grounds for discipline provided in subsection (1) of this section.

(b) If the Department elects to place a licensee on probation, the Department may impose:

(A) Restrictions on the scope of practice of the licensee;

(B) Requirements for specific training;

(C) Supervision of the practice of the licensee; or

(D) Other conditions the Department finds necessary for the protection of the public.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

309-034-0490
Appeal Process

(1) An appeal of a denial, suspension, probation, or revocation of a license may be requested in writing to the Department from a provider of psychiatric residential treatment services for children under 21 years of age on behalf of their employee or contractor.

(2) Within 10 days of the receipt of the appeal, the Department administrator or designee shall review all material relating to the denial, suspension, revocation or non-renewal, including any written documentation submitted by the licensee and provider within that time frame. The administrator or designee shall determine, based on review of the material, whether to sustain the decision. If the administrator or designee does not sustain the decision, the denial, suspension, revocation or non-renewal shall be rescinded immediately. The decision of the administrator or designee is subject to a contested case hearing under ORS Chapter 183 if requested within 90 days.

Stat. Auth.: HB 2626
Stats. Implemented: HB 2626
Hist.: MHD 5-2001(Temp), f. & cert. ef. 7-20-01 thru 1-15-02; MHD 1-2002, f. 1-14-02 cert. ef. 1-15-02

DIVISION 35

RESIDENTIAL TREATMENT FACILITIES FOR MENTALLY OR EMOTIONALLY DISTURBED PERSONS

309-035-0100
Purpose and Scope

(1) Purpose. These rules prescribe standards by which the Office of Mental Health and Addiction Services (OMHAS) approves residential treatment facilities for adults with mental or emotional disorders. The standards promote the well-being, health and recovery of adults with mental or emotional disorders through the availability of a wide range of residential service options. They prescribe how services will be provided in safe, secure and homelike environments that recognize the dignity, individuality and right to self-determination of each resident.

(2) Scope. These rules apply to residential treatment facilities for six to 15 residents and to residential treatment facilities serving 16 or more residents. Where standards differ based on the number of residents in a facility, the rules prescribe different requirements.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0105
Definitions

As used in these rules the following definitions apply:

(1) "Abuse" includes but is not limited to:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or provider, or other caregiver and the adult. For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

(e) Neglect that leads to physical harm or significant mental injury through withholding of services necessary to maintain health and well being;

(f) Abuse does not include spiritual treatments by a duly accredited practitioner of a recognized church or religious denomination when voluntarily consented to by the adult.

(g) Abuse also includes:

(A) Failure to act and/or neglect that results in imminent danger of causing physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to failure by a provider or staff to provide an adult with adequate food, clothing, shelter, medical care, supervision, or through tolerating or permitting abusive conduct toward an adult by any other person. However, no person will be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment;

(B) Verbal mistreatment by subjecting an adult to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation and threatening injury or withholding of services or supports, including implied or direct threat of termination of services;

(C) Placement of restrictions on a resident's freedom of movement. Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan;

(D) Financial exploitation by a caregiver including, but not limited to, unauthorized rate increases, borrowing from or loaning money to residents, witnessing wills in which a caregiver is beneficiary, adding caregiver's name to resident's bank accounts or other personal property without approval of the resident or his/her guardian or conservator and the PCP team; and

(E) Inappropriate expenditure of a resident's personal funds, theft of a resident's personal funds, use of a resident's personal funds for caregivers own benefit, commingling of a resident's funds with caregiver or other resident's funds, or a caregiver becoming guardian or conservator.

(2) "Administrator" means the person designated by the licensee as responsible for the daily operation and maintenance of the facility.

(3) "Adult" means an individual 18 years of age or older.

(4) "Aid to Physical Functioning" means any special equipment ordered for a resident by a Licensed Medical Professional or other qualified health care professional which maintains or enhances the resident's physical functioning.

(5) "Applicant" means the person(s) or entity who owns the business and is applying for the license.

(6) "Approved" means authorized or allowed by the Department.

(7) "Building Code" means the Oregon Structural Specialty Code adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(8) "Care" means services such as supervision; protection; assistance with activities of daily living such as bathing, dressing, grooming or eating; management of money; transportation; recreation; and the providing of room and board.

(9) "Community Mental Health Program (CMHP)" means the organization of all or a portion of services for persons with mental or emotional disorders, and developmental disabilities operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Office of Mental Health and Addiction Services (OMHAS).

(10) "Contract" means a formal written agreement between the community mental health program, Oregon Health Plan contractor or Office of Mental Health and Addiction Services (OMHAS) and a Residential Treatment Facility owner.

(11) "Crisis-Respite Services" means the provision of services to individuals for up to 30 days. Individuals receiving crisis-respite services are RTF residents.

(12) "DSM" means the "Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)," published by the American Psychiatric Association.

(13) "Department" means the Office of Mental Health and Addiction Services (OMHAS) of the Oregon Department of Human Services.

(14) "Direct Care Staff Person" means an employee responsible for providing services to residents.

(15) "Emergency Admission" means an admission to an RTF made on an urgent basis due to the pressing service needs of the individual.

(16) "Evacuation Capability" means the ability of occupants, including residents and staff as a group, to either evacuate the building or relocate from a point of occupancy to a point of safety as defined in the Oregon Structural Specialty Code. The category of evacuation capability is determined by documented evacuation drill times or scores on NFPA 101A worksheets. There are three categories of evacuation capability:

(a) Impractical (SR-2): A group, even with staff assistance, that cannot reliably move to a point of safety in a timely manner, determined by an evacuation capability score of five or greater or with evacuation drill times in excess of 13 minutes.

(b) Slow (SR-1): A group that can move to a point of safety in a timely manner, determined by an evacuation capability score greater than 1.5 and less than five or with evacuation drill times over three minutes but not in excess of 13 minutes.

(c) Prompt: A group with an evacuation capability score of 1.5 or less or equivalent to that of the general population or with evacuation drill times of three minutes or less. OMHAS is authorized to determine evacuation capability for RTFs in accordance with the National Fire Protection Association (NFPA) 101A 2000 edition. Facilities that are determined to be "Prompt" may be used in Group R occupancies classified by the building official, in accordance with the building code.

(17) "Facility" means one or more buildings and adjacent grounds on contiguous properties that are used in the operation of a Residential Treatment Facility.

(18) "Fire Code" means the Oregon Fire Code as adopted by the State of Oregon Fire Marshal.

(19) "Licensed Medical Professional (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon; or

(C) Physician's Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(20) "Licensee" means the person(s) or entity legally responsible for the operation of the facility to which the Department has issued a license.

(21) "Local Mental Health Authority (LMHA)" means the county court or board of county commissioners of one or more counties who choose to operate a CMHP or MHO; or, if the county declines to operate or contract for all or part of a CMHP or MHO, the board of directors of a public or private corporation which contracts with OMHAS to operate a CMHP or MHO for that county.

(22) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(23) "Mental or Emotional Disorder" means a primary Axis I or Axis II DSM diagnosis, other than mental retardation or a substance abuse disorder, that limits an individual's ability to perform activities of daily living.

(24) "Mental Health Assessment" means a determination by a Qualified Mental Health Professional of the client's need for mental health services. It involves collection and assessment of data pertinent to the client's mental health history and current mental health status obtained through interview, observation, testing, and review of previous treatment records. It concludes with determination of a DSM diagnosis or other justification of priority for mental health services, or a written statement that the person is not in need of community mental health services.

(25) "Mental Health Organization (MHO)" means an approved organization that provides most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs can be fully capitated health plans, community mental health programs, private mental health organizations or combinations thereof.

(26) "Nursing Care" means the practice of nursing by a licensed nurse, including tasks and functions that are delegated by a registered nurse to a person other than a licensed nurse, which are governed by ORS Chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR Chapter 851.

(27) "Office of Mental Health and Addiction Services (OMHAS)" means the Department of Human Services (DHS) agency responsible for the administration of state mental health and addiction services in accordance with federal and state laws, rules and regulations. OMHAS may delegate a portion of this responsibility to the CMHPs and to MHOs.

(28) "Owner" means the person(s) or entity legally responsible for the operation of the facility.

(29) "P.r.n. (pro re nata) Medications and Treatments" means those medications and treatments which have been ordered to be given as needed.

(30) "Program" means the residential treatment facility and may refer to the owner, staff and/or services as applicable to the context.

(31) "Progress Notes" means the notations in the resident record documenting significant information concerning the resident and summarizing progress made relevant to the objectives outlined in the residential service plan.

(32) "Protection" means the necessary actions taken by the program to prevent abuse or exploitation of the residents, to prevent self-destructive acts, and to safeguard residents, property and funds.

(33) "Resident" means any adult residing in a facility who receives services on a 24-hour basis, except as excluded under ORS 443.400(3).

(34) "Residential Service Plan" means an individualized, written plan outlining the care and treatment to be provided to a resident in or through the facility based upon an individual assessment of care and treatment needs. The residential service plan may be a section or subcomponent of the individual's overall plan for mental health treatment when the RTF is operated by a mental health service agency that provides other services to the resident.

(35) "Residential Treatment Facility (RTF)" means a facility that is operated to provide services on a 24-hour basis for six or more residents.

(36) "Restraints" means any chemical or physical methods or devices that are intended to restrict or inhibit the movement, functioning, or behavior of a resident.

(37) "Seclusion" means placing an individual in a locked room. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut.

(38) "Secure Residential Treatment Facility" means any residential treatment facility, or portion thereof, that restricts a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures. Such locking devices will be installed in accordance with Building Code requirements.

(39) "Services" means the care and treatment provided to residents as part of the Residential Treatment Facility program.

(40) "Supervision" means the daily observation, and monitoring of residents by direct care staff or oversight of staff by the administrator or administrator's designee, as applicable to the context.

(41) "Termination of Residency" means the time at which the resident ceases to live in the RTF, and includes the transfer of the resident

to another facility, but does not include absences from the facility for the purpose of taking a planned vacation, visiting family or friends, or receiving time-limited medical or psychiatric treatment.

(42) "Treatment" means a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities consistent with ORS 443.400(12).

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.010 & 443.450

Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)

Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHS 13-2007, f. & cert. ef. 8-31-07

309-035-0110
Licensing

(1) License Required. The Department will license any facility that meets the definition of a residential treatment facility and serves adults with a mental or emotional disorder. In the case of a facility serving another category of residents in addition to adults with a mental or emotional disorder, the Department responsible for licensure will be determined by the Director of the Department of Human Services. No person or governmental unit acting individually or jointly with any other person or governmental unit will establish, maintain, manage, or operate a residential treatment facility without a license issued by the Department.

(2) Initial Application. An application for a license will be accompanied by the required fee and submitted to the Department using the forms or format required by the Department. The following information will be required in the application:

(a) Full and complete information as to the identity and financial interest of each person, including stockholders, having a direct or indirect ownership interest of five percent or more in the facility and all officers and directors in the case of facilities operated or owned by a corporation.

(b) Name and resume of the administrator of the facility;

(c) Location (street address) of the facility and mailing address;

(d) Maximum number of residents to be served at any one time, their age range and evacuation capability;

(e) Proposed annual budget identifying sources of revenue and expenses;

(f) Signed criminal record authorizations for all persons involved in the operation of the RTF who will have contact with the residents;

(g) A complete set of policies and procedures;

(h) Facility plans and specifications; and

(i) Such other information as the Department may reasonably require.

(3) Plans and Design Approval. A complete set of plans and specifications will be submitted to the Department at the time of initial application, whenever a new structure or addition to an existing structure is proposed, or when significant alterations to an existing facility are proposed. Plans will meet the following criteria:

(a) Plans will be prepared in accordance with the Building Code and requirements of OAR 309-035-0125;

(b) Plans will be to scale and sufficiently complete to allow full review for compliance with these rules; and

(c) Plans will bear the stamp of an Oregon licensed architect or engineer when required by the Building Code.

(4) Necessary Approvals. Prior to approval of a license for a new or renovated facility, the applicant will submit the following to the Department:

(a) One copy of written approval to occupy the facility issued by the city or county building codes authority having jurisdiction;

(b) One copy of the fire inspection report from the State Fire Marshal or local jurisdiction indicating that the facility complies with the Fire Code;

(c) When the facility is not served by an approved municipal water system, one copy of the documentation indicating that the state or county health agency having jurisdiction has approved the water supply in accordance with OAR chapter 333, Health Services rules to public water systems.

(d) When the facility is not connected to an approved municipal sewer system, one copy of the sewer or septic system approval from the Department of Environmental Quality or local jurisdiction.

(5) Required Fees. The fee for each residential treatment facility license application is $60. No fee is required in the case of a governmentally operated residential treatment facility.

(6) Renewal Application. A license is renewable upon submission of a renewal application in the form or format required by the Department and a non-refundable fee of $60, except that no fee will be required of a governmentally operated facility.

(a) Filing of an application for renewal before the date of expiration extends the effective date of the current license until the Department takes action upon the renewal application.

(b) The Department will refuse to renew a license if the facility is not in substantial compliance with these rules, or if the State Fire Marshal or authorized representative has given notice of noncompliance.

(7) Review Process. Upon receipt of an application and fee, the Department will conduct an application review. Initial action by the Department on the application will begin within 30 days of receipt of all application materials. The review will:

(a) Include a complete review of application materials;

(b) Determine whether the applicant meets the qualifications outlined in ORS 443.420 including:

(A) Demonstrates an understanding and acceptance of these rules;

(B) Is mentally and physically capable of providing services for residents;

(C) Employs or utilizes only individuals whose presence does not jeopardize the health, safety, or welfare of residents; and

(D) Provides evidence satisfactory to the Department of financial ability to comply with these rules.

(c) Include a site inspection; and

(d) Conclude with a report stating findings and a decision on licensing of the facility.

(8) Findings of Noncompliance. The Department will require an owner to submit and complete a plan of correction for each finding of noncompliance with these rules.

(a) If the finding(s) of noncompliance substantially impact the welfare, health and/or safety of residents, the plan of correction will be submitted and completed prior to issuance of a license. In the case of a currently operating RTF, such findings may result in suspension or revocation of a license.

(b) If it is determined that the finding(s) of noncompliance do not threaten the welfare, health or safety of residents and the facility meets other requirements of licensing, a license may be issued or renewed, and the plan of correction will be submitted and completed as a condition of licensing.

(c) The Department will specify required documentation and set the time lines for the submission and completion of plans of correction in accordance with the severity of the finding(s).

(d) The Department will review and approve each plan of correction. If the plan of correction does not adequately remedy the finding of noncompliance, the Department will require a revised plan of correction, and/or take action to apply civil penalties or deny, revoke or suspend the license.

(e) The RTF owner may appeal the finding of noncompliance or the disapproval of a plan of correction by submitting a request for reconsideration in writing to the Administrator of the Department. The Administrator of the Department or designee will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Administrator of the Department will be final.

(9) Variance. The Department may grant a variance to these rules based upon a demonstration by the applicant that an alternative method or different approach provides equal or greater program effectiveness and does not adversely impact the welfare, health or safety of residents.

(a) Variance Application. The RTF owner requesting a variance will submit, in writing, an application to the Department which identifies the section of the rules from which the variance is sought, the reason for the proposed variance, the proposed alternative method or different approach, and signed documentation from the CMHP indicating approval of the proposed variance.

(b) Office of Mental Health and Addiction Services Review. The Assistant Administrator for the Department's Office of Mental Health and Addiction Services (OMHAS), or designee, will review and approve or deny the request for a variance.

(c) Notification of Decision. The Department will notify the RTF owner of the decision in writing within 30 days after receipt of the application. A variance may be implemented only after receipt of written approval from the Department.

(d) Appeal of Decision. The RTF owner may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Administrator of the Department. The Administrator of the Department will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Administrator of the Department will be final.

(e) Duration of the Variance. A variance will be reviewed by the Department at least every two years and may be revoked or suspended based upon a finding that the variance adversely impacts the welfare, health or safety of the RTF residents.

(10) Issuance of License. Upon finding that the applicant is in substantial compliance with these rules, the Department will issue a license.

(a) The license issued will state the name of the owner of the facility, the name of the administrator, the address of the facility to which the license applies, the maximum number of residents to be served at any one time and their evacuation capability, the type of facility, and such other information as the Department deems necessary.

(b) A residential treatment facility license will be effective for two years from the date issued unless sooner revoked or suspended.

(c) The residential treatment facility license is not transferable or applicable to any location, facility, or management other than that indicated on the application and license.

(11) Conditions of License. The license will be valid under the following conditions:

(a) The residential treatment facility will not be operated or maintained in combination with a nursing facility, hospital, retirement facility, or other occupancy unless licensed, maintained, and operated as a separate and distinct part. Each residential treatment facility will have sleeping, dining and living areas for use only by its own residents, employees and invited guests.

(b) The license will be retained in the facility and available for inspection at all times.

(c) Each license will be considered void immediately upon suspension or revocation of the license by the Department, or if the operation is discontinued by voluntary action of the licensee, or if there is a change of ownership.

(12) Site Inspections. Department staff will visit and inspect every residential treatment facility at least, but not limited to, once every two years to determine whether it is maintained and operated in accordance with these rules. The RTF owner/applicant will allow Department staff entry and access to the facility and residents for the purpose of conducting the inspections.

(a) Department staff will review methods of resident care and treatment, records, the condition of the facility and equipment, and other areas of operation.

(b) All records, unless specifically excluded by law, will be available to the Department for review.

(c) The State Fire Marshal or authorized representative(s) will, upon request, be permitted access to the facility, fire safety equipment within the facility, safety policies and procedures, maintenance records of fire protection equipment and systems, and records demonstrating the evacuation capability of facility occupants.

(13) Investigation of Complaints and Alleged Abuse. Incidents of alleged abuse covered by ORS 430.735 through 430.765 will be reported and investigated in accordance with OAR 410-009-0050 through 410-009-0160. Department staff will investigate complaints and other alleged abuse made regarding residential treatment facilities, will cause a report to be filed, and will take appropriate action under these rules. The Department may delegate the investigation to a CMHP or other appropriate entity.

(14) Denial, Suspension or Revocation of License. The Department will deny, suspend or revoke a license where it finds there has been substantial failure to comply with these rules; or where the State Fire Marshal or authorized representative certifies that there is failure to comply with the Fire Code.

(a) In cases where there exists an imminent danger to the health or safety of residents, a license may be suspended immediately.

(b) Such revocation, suspension, or denial will be done in accordance with rules of the Department under ORS Chapter 183.

(15) Reporting Changes. Each licensee will report promptly to the Department any significant changes to information supplied in the application or subsequent correspondence. Such changes include, but are not limited to, changes in the facility name, owner entity, administrator, telephone number and mailing address. Such changes also include, but are not limited to, changes in the facility's physical plant, policies and procedures or staffing pattern when such changes are significant or impact the health, safety or well-being of residents.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0113
Contracts and Rates

(1) Contracts. Residential Treatment Facility operators providing services funded with state service payments will enter into a contract with the local community mental health program, the Department or other Department-approved party. The contract does not guarantee that any number of persons eligible for Department funded services will be referred to or maintained in the facility.

(2) Rates. Rates for all services and the procedures for collecting payments from residents and/or payees will be specified in a fee policy and procedures. The fee policy and procedures will describe the schedule of rates, conditions under which rates may be changed, acceptable methods of payment, and the policy on refunds at the time of termination of residency.

(a) For residents whose services are funded by the Department, reimbursement for services will be made according to the rate schedule outlined in the contract. Room and board payments for residents receiving Social Security benefits or public assistance will be in accordance with rates determined by the Department.

(b) For private paying residents, the program will enter into a signed agreement with the resident, and/or if applicable, resident's guardian, payee or conservator. This agreement will include but not be limited to a description of the services to be provided; the schedule of rates; conditions under which the rates may be changed; and policy on refunds at the time of termination of residency.

(c) Before increasing rates or modifying payment procedures, the program will provide 30 days advance notice of the change to all residents, payees, guardians or conservators, as applicable.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0115
Administrative Management

(1) Licensee. The licensee will be responsible for insuring that the facility is operated in compliance with these rules and all other applicable federal, state and local laws and regulations.

(2) Administrator. The licensee will employ an administrator who:

(a) Has background including special training, experience, and other demonstrated ability in providing care and treatment appropriate to the residents served in the facility;

(b) Has a documented criminal record clearance and no history of abusive behavior;

(c) Will insure that the RTF operates in accordance with the standards outlined in these rules;

(d) Will oversee the daily operation and maintenance of the RTF and will be available to perform administrative duties at the facility at least 20 hours per week;

(e) Will develop and administer written policies and procedures to direct the operation of the RTF and the provision of services to residents;

(f) Will insure that qualified staff are available, in accordance with the staffing requirements specified in these rules;

(g) Will supervise or provide for the supervision of staff and others involved in the operation of the program;

(h) Will maintain facility, personnel and resident records;

(i) Will report regularly to the licensee on the operation of the RTF; and

(j) Will delegate authority and responsibility for the operation and maintenance of the facility to a responsible staff person whenever the Administrator is absent from the RTF. This authority and responsibility will not be delegated to a resident.

(3) Policies and Procedures. Policies and procedures will be developed, updated as necessary, maintained in a location easily accessible for staff reference, and made available to others upon reasonable request. They will be consistent with requirements of these rules, and address, but not be limited to:

(a) Personnel practices and staff training;

(b) Resident selection, admission and termination;

(c) Fire drills, emergency procedures, resident safety and abuse reporting;

(d) Health and sanitation;

(e) Records;

(f) Residential service plan, services and activities;

(g) Behavior management, including the use of seclusion or restraints;

(h) Food Service;

(i) Medication administration and storage;

(j) Resident belongings, storage and funds;

(k) Resident rights and advance directives;

(l) Complaints and grievances;

(m) Facility maintenance;

(n) Evacuation capability determination; and

(o) Fees and money management.

(4) House Rules. The RTF will develop reasonable house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies and smoking. The house rules will be consistent with resident rights as delineated in OAR 309-035-0155. House rules will be posted in an area readily accessible to residents. House rules will be reviewed and updated, as necessary. Residents will be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984 (Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; ; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0117
Records

(1) General Requirements. Records will be maintained to document the legal operation of the program, personnel practices and resident services. All records will be properly obtained, accurately prepared, safely stored and readily available within the facility. All entries in records required by these rules will be in ink, indelible pencil, or approved electronic equivalent prepared at the time, or immediately following, the occurrence of the event being recorded; be legible; and be dated and signed by the person making the entry. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.

(2) Program Records. Records documenting the legal operation of the RTF will include, but not be limited to:

(a) Written approval for occupancy of the building by the county or city having jurisdiction, any building inspection reports, zoning verifications, fire inspection reports or other documentation pertaining to the safe and sanitary operation of the facility issued during the development or operation of the facility;

(b) Application for license, related correspondence and site inspection reports;

(c) Program operating budget and related financial records;

(d) Payroll records, employee schedules and time sheets;

(e) Materials Safety and Data Sheets;

(f) Fire drill documentation;

(g) Fire alarm and sprinkler system maintenance and testing records;

(h) Incident reports; and

(i) Policy and procedure manual.

(3) Personnel Records. Records documenting personnel actions will include:

(a) Job descriptions for all positions; and

(b) Individual employee records including, but not limited to, written documentation of employee identifying information and qualifications, criminal record clearance, T.B. test results, Hepatitis B status, performance appraisals, and documentation of pre-service orientation and other training.

(4) Resident Records. An individual resident record will be maintained for each resident and include:

(a) An easily accessible summary sheet which includes, but is not limited to the resident's name, previous address, date of admission to the facility, sex, date of birth, marital status, legal status, religious preference, Social Security number, health provider information, evacuation capability, diagnosis(es), major health concerns, medication allergies, information indicating whether advance mental health and health directives and/or burial plan have been executed, and the name of person(s) to contact in case of emergency;

(b) The names, addresses and telephone numbers of the resident's legal guardian or conservator, parent(s), next of kin, or other significant person(s); physician(s) or other medical practitioner(s); dentist; CMHP case manager or therapist; day program, school or employer; and any governmental or other agency representative(s) providing services to the resident;

(c) A mental health assessment and background information identifying the resident's residential service needs;

(d) Advance mental health and health directives, burial plans or location of these (as available);

(e) Residential Service Plan and copy(ies) of plan(s) from other service provider(s).

(f) Documentation of the resident's progress and any other significant information including, but not limited to, progress notes, progress summaries, any use of seclusion or restraints, and correspondence concerning the resident; and

(g) Health-related information and up-to-date information on medications in accordance with OAR 309-035-0175.

(5) Records for Crisis-respite Residents. For residents receiving crisis-respite services, an attempt will be made to obtain and maintain records as outlined in OAR 309-035-0117(4). Because it may not be possible to assemble complete records during the crisis-respite resident's short stay, the program will, at a minimum, maintain records in accordance with requirements outlined in OAR 309-035-0145, 309-035-0150, 309-035-0159, and 309-035-0175.

(6) Storage. All resident records will be stored in a weatherproof and secure location. Access to records will be limited to the Administrator and direct care staff unless otherwise allowed in these rules.

(7) Confidentiality. All resident records will be kept confidential. A signed release of information will be obtained for any disclosure from resident records in accordance with all applicable laws and rules.

(8) Resident Access to His/Her Record. A resident, or guardian (as applicable), will be allowed to review and obtain a copy of his/her resident record as allowed in ORS 179.505(9).

(9) Transfer of Records. Pertinent information from records of residents who are being transferred to another facility will be transferred with the resident. A signed release of information will be obtained in accordance with applicable laws and rules.

(10) Maintenance of Records. The facility will keep all records, except those transferred with a resident, for a period of three years.

(11) Administrative Changes. If an RTF changes ownership or Administrator, all resident and personnel records will remain in the facility. Prior to the dissolution of any RTF, the Administrator will notify the Department in writing as to the location and storage of resident records or those records will be transferred with the residents.

(12) Resident Contributions to Record. If a resident or guardian (as applicable) disagrees with the content of the resident record, or otherwise desires to provide documentation for the record, the resident or guardian (as applicable) may provide material in writing that then will become part of the resident record.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0120
Staffing

(1) Staff Qualifications. A job description will be available for each staff position and specify qualifications and job duties.

(a) Any staff person hired to provide direct care to residents will be at least 18 years of age, be capable of implementing the facility's emergency procedures and disaster plan, and be capable of performing other duties of the job as described in the job description.

(b) All staff who will have contact with residents will provide evidence of a criminal record clearance, in accordance with OAR 407-007-0200 through 407-007-0380.

(c) In accordance with OAR 333-071-0057 and 437, division 2, Subdivision Z, 4f (1)(2), all RTF staff who have contact with residents

will be tested for tuberculosis and Hepatitis B within two weeks of first employment, additional testing will take place as deemed necessary; and the employment of staff who test positive for tuberculosis will be restricted if necessary.

(d) All staff will meet other qualifications when required by a contract or financing arrangement approved by the Department.

(2) Personnel Policies. Personnel policies will be made available to all staff and will describe hiring, leave, promotion and disciplinary practices.

(3) Staff Training. The administrator will provide or arrange a minimum of 16 hours pre-service orientation and 8 hours in-service training annually for each employee.

(a) Pre-service training for direct care staff will include, but not be limited to, a comprehensive tour of the facility; a review of emergency procedures developed in accordance with OAR 309-035-0130; a review of facility house rules, policies and procedures; background on mental and emotional disorders; an overview of resident rights; medication management procedures; food service arrangements; a summary of each resident's assessment and residential service plan; and other information relevant to the job description and scheduled shift(s).

(b) In-service training will be provided on topics relevant to improving the care and treatment of residents in the facility and meeting the requirements in these administrative rules. In-service training topics include, but are not limited to, implementing the residential service plan, behavior management, daily living skills development, nutrition, first aid, understanding mental illness, sanitary food handling, resident rights, identifying health care needs, and psychotropic medications.

(4) General Staffing Requirements. The licensee and administrator are responsible for assuring that an adequate number of staff are available at all times to meet the treatment, health and safety needs of residents. Regardless of the minimum staffing requirements outlined below, staff will be scheduled to insure safety and to correspond to the changing needs of residents. Minimum staffing requirements are as follows:

(a) In facilities serving 6 to 20 residents, there will be at least one direct care staff person on duty at all times.

(b) In facilities serving 21 to 35 residents, there will be at least two direct care staff on duty from 7:00 a.m. to 9:00 p.m. and at least one direct care staff person on duty from 9:00 p.m. to 7:00 a.m.

(c) In facilities serving 36 to 50 residents, there will be at least three direct care staff on duty from 7:00 a.m. to 9:00 p.m. and at least two direct care staff on duty from 9:00 p.m. to 7:00 a.m.

(d) In facilities serving 51 to 65 residents, there will be at least four direct care staff on duty from 7:00 a.m. to 9:00 p.m. and at least two direct care staff on duty from 9:00 p.m. to 7:00 a.m.

(e) In the case of a specialized RTF, staffing requirements outlined in the contractual agreement for specialized services will be implemented.

(f) Direct care staff on night duty will be awake and dressed at all times. In facilities where residents are housed in two or more detached buildings, direct care staff will monitor each building at least once an hour during the night shift. An approved method for alerting staff to problems will be in place. This method must be accessible to and usable by the residents.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0125
Facility Requirements

(1) Compliance with Building and Fire Codes. Each residential treatment facility will meet the requirements for approved Group SR or I occupancies in the Building Code and the Fire Code in effect at the time of original licensure. When a change in facility use results in a new building occupancy classification, the facility will meet the requirements for approved Group SR or I occupancies in the Building Code in effect at the time of such change. If occupants are capable of evacuation within 3 minutes refer to Group R occupancies.

(2) Accessibility for Persons with Disabilities. Facilities will be accessible as follows:

(a) Those facilities, or portions of facilities, that are licensed, constructed or renovated after January 26, 1992, and that are covered multi-family dwellings or public accommodations, will meet the physical accessibility requirements in Chapter 11 of the Oregon Structural Specialty Codes. These codes specify requirements for public accommodations as defined in the Americans with Disabilities Act under Title III and for buildings qualifying as multi-family dwellings as defined in the Fair Housing Act, as amended in 1988.

(b) In order to insure program accessibility under Title II of the Americans with Disabilities Act, the Department may require additional accessibility improvements.

(c) Any accessibility improvements made to accommodate an identified resident will be in accordance with the specific needs of the resident.

(3) Outdoor Areas. An accessible outdoor area is required and will be made available to all residents. For facilities, or portions thereof, licensed on or after June 1, 1998, a portion of the accessible outdoor area will be covered and have an all weather surface, such as a patio or deck.

(4) General Storage. The facility will include sufficient and safe storage areas. These will include but not be limited to:

(a) Storage for a reasonable amount of resident belongings beyond that available in resident sleeping rooms will be provided appropriate to the size of the facility;

(b) All maintenance equipment, including yard maintenance tools, will be maintained in adequate storage space. Equipment and tools which pose a danger to facility residents will be kept in locked storage;

(c) Storage areas necessary to insure a functional, safe and sanitary environment consistent with OAR 309-035-0125, 309-035-0130, 309-035-0135, 309-035-0140, 309-035-0170, and 309-035-0175.

(5) Hallways. For facilities initially licensed on or after June 1, 1998, all resident use areas and resident units will be accessible through temperature controlled common areas or hallways with a minimum width of 36 inches except that a minimum width of 48 inches will be provided along the route to accessible bedrooms and bathrooms and between common areas and required exits.

(6) Administrative Areas. Sufficient space will be provided for confidential storage of both resident and business records, for staff use in completing record-keeping tasks, and for a telephone. Other equipment including fire alarm panels and other annunciators will be installed in an area readily accessible to staff in accordance with the Fire Code.

(7) Resident Sleeping Rooms. Resident sleeping quarters will be provided in rooms separated from other areas of the facility by an operable door with an approved latching device.

(a) For facilities licensed prior to June 1, 1998, resident sleeping rooms will include a minimum of 60 square feet per resident and allow for a minimum of three feet between beds.

(b) For facilities, or portions thereof, initially licensed on or after June 1, 1998, each resident sleeping room will be limited to one or two residents. At least ten percent, but no less than one, of the resident sleeping rooms will be accessible for persons with mobility disabilities. All resident sleeping rooms will include a minimum of 70 square feet per resident exclusive of closets, vestibules and bathroom facilities and allow a minimum of three feet between beds.

(c) A clothes closet, with adequate clothes hanging rods will be accessible within each sleeping room for storage of each resident's clothing and personal belongings. For facilities initially licensed on or after June 1, 1998, built-in closet space will be provided totaling a minimum of 64 cubic feet for each resident. In accessible sleeping rooms, the clothes hanging rod height will be adjustable or no more than 54 inches in height to insure accessibility for persons in wheelchairs.

(d) Each resident sleeping room will have exterior window(s) with a combined area at least one-tenth of the floor area of the room. Sleeping room windows will be equipped with curtains or blinds for privacy and control of light. For facilities, or portions of facilities, initially licensed on or after June 1, 1998, an escape window will be provided consistent with Building Code requirements.

(8) Bathrooms. Bathing and toilet facilities will be conveniently located for resident use, provide permanently wired light fixtures that illuminate all parts of the room, provide individual privacy for residents, provide a securely affixed mirror at eye level, be adequately ventilated, and include sufficient facilities specially equipped for use by persons with a physical disability in buildings serving such persons.

(a) In facilities licensed prior to June 1, 1998, a minimum of one toilet and one lavatory will be available for each eight residents, and one bathtub or shower will be available for each ten residents.

(b) In facilities, or portions of facilities, initially licensed on or after June 1, 1998, a minimum of one toilet and one lavatory will be available for each six residents, and a minimum of one bathtub or shower will be available for each ten residents, where these fixtures are not available in individual resident rooms. At least one centralized bathroom along an accessible route will be designed for disabled access in accordance with Chapter 11 of the Oregon Structural Specialty Code. For facilities licensed for more than 16 residents, there will be at least one separate toilet and lavatory provided for staff and visitor use.

(9) Common Use Rooms. The facility will include lounge and activity area(s) for social and recreational use, exclusively by residents, staff and invited guests, totaling 15 square feet per resident.

(10) Laundry and Related Space. Laundry facilities will be separate from food preparation and other resident use areas. When residential laundry equipment is installed, the laundry facilities may be located to allow for both resident and staff use. In facilities initially licensed on or after June 1, 1998, separate residential laundry facilities will be provided when the primary laundry facilities are located in another building, are of commercial type, or are otherwise not suitable for resident use. The following will be included in the primary laundry facilities:

(a) Countertops or spaces for folding table(s) sufficient to handle laundry needs for the facility;

(b) Locked storage for chemicals and equipment;

(c) Outlets, venting and water hook-ups according to state building code requirements. Washers will have a minimum rinse temperature of 155 degrees Fahrenheit (160 degrees Fahrenheit recommended) unless a chemical disinfectant will be used; and

(d) Sufficient storage and handling space to insure that clean laundry is not contaminated by soiled laundry.

(11) Kitchen. Kitchen facilities and equipment in facilities licensed for 16 or fewer residents may be of residential type except as required by the state building code and Fire Code or local agencies having jurisdiction. Facilities serving 17 or more residents will have facilities and equipment meeting Food Sanitation Rules of Health Services under OAR chapter 333 as applicable. For all kitchens, the following will be included:

(a) Dry storage space, not subject to freezing, in cabinets or a separate pantry for a minimum of one week's supply of staple foods;

(b) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space for a minimum of two days' supply of perishable foods;

(c) In facilities licensed to serve 16 or fewer residents, a dishwasher will be provided (may be approved residential type) with a minimum final rinse temperature of 155 degrees Fahrenheit (160 degrees recommended), unless chemical disinfectant is used. In facilities licensed to serve 17 or more residents, a commercial dishwasher is required as specified in Health Services Food Sanitation Rules;

(d) In facilities licensed to serve 16 or fewer residents, a separate food preparation sink and hand washing sink will be provided. In facilities licensed to serve 17 or more residents, a triple pot wash sink will be provided unless pots are sanitized in the dishwasher, in addition to a food preparation sink and separate hand washing sink;

(e) Smooth, nonabsorbent and cleanable counters for food preparation and serving;

(f) Appropriate storage for dishes and cooking utensils designed to be free from potential contamination;

(g) Stove and oven equipment for cooking and baking needs; and

(h) Storage for a mop and other cleaning tools and supplies used for food preparation, dining and adjacent areas. Such cleaning tools will be maintained separately from those used to clean other parts of the facility. In facilities initially licensed on or after June 1, 1998, and licensed to serve 17 or more residents, a separate janitor closet or alcove will be provided with a floor or service sink and storage for cleaning tools and supplies.

(12) Dining Area. A separate dining room or area where meals are served will be provided for the exclusive use of residents, employees, and invited guests.

(a) In facilities licensed prior to June 1, 1998, the dining area will seat at least half of the residents at one time with a minimum area of 15 square feet per resident.

(b) In facilities, or portions of facilities, initially licensed on or after June 1, 1998, dining space will be provided to seat all residents with a minimum area of 15 square feet per resident, exclusive of serving facilities and required exit pathways.

(13) Details and Finishes. All details and finishes will meet the finish requirements of applicable sections of the Building Code and the Fire Code.

(a) Surfaces. Surfaces of all walls, ceilings, windows and equipment will be readily cleanable. In facilities, or portions of facilities, initially licensed on or after June 1, 1998, the walls and ceilings in the kitchen, laundry and bathing areas will be smooth, nonabsorbent, and readily cleanable, and kitchen walls in facilities licensed to serve 17 or more residents will comply with Health Services Food Sanitation Rules, OAR chapter 333, division 150 through 160.

(b) Flooring. In facilities, or portions of facilities, initially licensed on or after June 1, 1998, flooring, thresholds and floor junctures will be designed and installed to prevent a tripping hazard and to minimize resistance for passage of wheelchairs and other ambulation aids. In addition, hard surface floors and base will be free from cracks and breaks, and bathing areas will have non-slip surfaces.

(c) Doors. In facilities, or portions of facilities, initially licensed on or after June 1, 1998, all doors to resident sleeping rooms, bathrooms and common use areas will provide a minimum clear opening of 32 inches. Lever type door hardware will be provided on all doors used by residents. If locks are used on doors to resident sleeping rooms, they will be interactive to release with operation of the inside door handle and be master-keyed from the corridor side. Exit doors will not include locks which prevent evacuation except in accordance with Building Code and Fire Code requirements and with written approval of the Department. An exterior door alarm or other acceptable system may be provided for security purposes and to alert staff when resident(s) or others enter or exit the facility.

(d) Handrails. Handrails will be provided on all stairways as specified in the Building Code.

(14) Heating and Ventilating. All areas of the facility will be adequately ventilated and temperature controlled in accordance with the Mechanical and Building Code requirements.

(a) Temperature Control. All facilities will include heating equipment capable of maintaining a minimum temperature of 68 degrees Fahrenheit at a point three inches above the floor. During times of extreme summer heat, fans will be made available when air conditioning is not provided.

(b) Exhaust Systems. All toilet and shower rooms will be adequately ventilated. In facilities initially licensed on or after June 1, 1998, toilet and shower rooms will be equipped with a mechanical exhaust fan or central exhaust system which discharges to the outside.

(c) Fireplaces, Furnaces, Wood Stoves and Boilers. Where used, design and installation will meet standards of the Oregon Mechanical Specialty Code and the Boiler Specialty Code, as applicable.

(d) Water Temperature. In resident areas, hot water temperatures will be maintained within a range of 110 to 120 degrees Fahrenheit. Hot water temperatures in laundry and kitchen areas will be at least 155 degrees Fahrenheit.

(15) Electrical. All wiring systems will meet the standards of Oregon Electrical Specialty Code in effect on the date of installation, and all electrical devices will be properly wired and in good repair.

(a) When not fully grounded, circuits in resident areas will be protected by GFCI type receptacles or circuit breakers as an acceptable alternative.

(b) All electrical circuits will be protected by circuit breakers or non-interchangeable plug-type fuses in fuse boxes. Electrical loads on distribution panels and circuits will be limited in accordance with the Oregon Electrical Specialty Code.

(c) A sufficient supply of electrical outlets will be provided to meet resident and staff needs. (The use of extension cords will be in accordance with the rules of the Office of State Fire Marshal and the Department of Health Services.)

(d) Lighting fixtures will be provided in each resident bedroom and bathroom, switchable near the entry door, and in other areas as required to meet task illumination.

(e) In facilities, or portions of facilities, initially licensed on or after June 1, 1998, lighting fixtures that illuminate evacuation pathways will be operable within 10 seconds during a failure of the normal power supply and provide illumination for a period of at least two hours.

(16) Plumbing. All plumbing will meet the Oregon Plumbing Specialty Code in effect on the date of installation, and all plumbing fixtures will be properly installed and in good repair.

(17) Telephones. The facility will provide adequate access to telephones for private use by residents. In facilities initially licensed on or after June 1, 1998, a phone for resident use will be provided in addition to the phone used by staff. The facility may establish reasonable house rules governing phone use to insure equal access by all residents. Each resident or guardian (as applicable) will be responsible for payment of long distance phone bills where the calls were initiated by the resident, unless other mutually agreed arrangements have been made.

(18) Smoking. Smoking is not allowed in sleeping areas. If there is a designated smoking area, it will be separated from other common areas. Indoor smoking areas will be equipped with a mechanical exhaust fan or central exhaust system which discharges to the outside. Furniture used in designated smoking areas will be non-flammable and without crevasses. In facilities, or portions of facilities, initially licensed on or after June 1, 1998, indoor smoking areas will be separated from other parts of the facility by a self-closing door and contain sprinkler protection or heat detectors.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef.; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0130
Safety

(1) Training on Safety Procedures. All staff will be trained in staff safety procedures prior to beginning their first regular shift. All residents will be trained in resident safety procedures as soon as possible during their first 72 hours of residency.

(2) Emergency Procedure and Disaster Plan. A written procedure and disaster plan will be approved by the State Fire Marshal or authorized representative. The plan will cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes and floods. The plan will be posted by the phone and immediately available to the administrator and employees. The plan will include diagrams of evacuation routes, and these will be posted. The plan will specify where staff and residents will go if the facility becomes uninhabitable. The plan will be kept up to date and will include:

(a) Emergency instructions for employees;

(b) The telephone numbers of the local fire department, police department, the poison control center, the administrator, the administrator's designee, and other persons to be contacted in emergencies; and

(c) Instructions for the evacuation of residents and employees.

(3) Combustible and Hazardous Materials. Noncombustible and nonhazardous materials will be used whenever possible. When necessary to the operation of the facility, flammable and combustible liquids and other hazardous materials will be safely and properly stored in clearly labeled, original containers in areas inaccessible to residents in accordance with the Fire Code. Any quantities of combustible and hazardous materials maintained will be the minimum necessary.

(4) Poisonous and Other Toxic Materials. Non-toxic cleaning supplies will be used whenever available. Poisonous and other toxic materials will be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) Evacuation Capability. Evacuation capability categories are based upon the ability of the residents and staff as a group to evacuate the building or relocate from a point of occupancy to a point of safety. Buildings will be constructed and equipped according to a designated evacuation capability for occupants. Categories of evacuation capability include "Impractical" (SR- 2) or "Slow" (SR- 1). The evacuation capability designated for the facility will be documented and maintained in accordance with NFPA 101A.

(a) Only persons assessed to be capable of evacuating in accordance with the designated facility evacuation capability will be admitted to the facility.

(b) Persons experiencing difficulty with evacuating in a timely manner will be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances, the facility will consider increasing staff levels, changing staff assignments, offering to change the resident's room assignment, arranging for special equipment, and taking other actions that may assist the resident. Residents who still cannot evacuate the building safely in the allowable period of time will be assisted with transferring to another facility with an evacuation capability designation consistent with the individual's documented evacuation capability.

(6) Evacuation Drills. Every resident will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the fire code.)

(a) At least once every three months, the drill will be conducted during resident sleeping hours.

(b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.

(c) Any resident failing to evacuate within the established time limits will be provided with special assistance and a notation made in the resident record.

(d) Written evacuation records will be maintained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.

(7) Unobstructed Egress. All stairways, halls, doorways, passageways, and exits from rooms and from the building will be unobstructed.

(8) Fire Extinguishers. The provider will provide and maintain one or more 2A10BC fire extinguishers on each floor in accordance with the Fire Code.

(9) Fire Alarms and Smoke Detectors. Approved fire alarms and smoke detectors will be installed according to Building Code and Fire Code requirements. These alarms will be set off during each evacuation drill. The facility will provide appropriate signal devices for persons with disabilities who do not respond to the standard auditory alarms. All of these devices will be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction.

(10) Sprinkler Systems. Sprinkler systems will be installed in compliance with the Building Code and maintained in accordance with rules adopted by the State Fire Marshal.

(11) First Aid Supplies. First aid supplies will be readily accessible to staff. All supplies will be properly labeled.

(12) Portable Heaters. Portable heaters are a recognized safety hazard and will not be used.

(13) Safety Program. A safety program will be developed and implemented to identify and prevent the occurrence of hazards at the facility. Such hazards may include, but are not limited to, dangerous substances, sharp objects, unprotected electrical outlets, use of extension cords or other special plug-in adapters, slippery floors or stairs, exposed heating devices, broken glass, inadequate water temperatures, overstuffed furniture in smoking areas, unsafe ashtrays and ash disposal, and other potential fire hazards.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984 (Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0135
Sanitation

(1) Water Supply. The water supply in the facility will meet the requirements of the current rules of Health Services governing domestic water supplies.

(a) A municipal water supply will be utilized if available.

(b) When the facility is not served by an approved municipal water system, and the facility qualifies as a public water system according to OAR 333-061-0020(127), Oregon Health Services rules for public water systems, then the facility will comply with the OAR chapter 333 rules of the Oregon Health Services pertaining to public water systems. These include requirements that the drinking water be tested for total coliform bacteria at least quarterly, and nitrate at least annually, and reported to Health Services. For adverse test results, these rules require that repeat samples and corrective action be taken

to assure compliance with water quality standards, that public notice be given whenever a violation of the water quality standards occurs, and that records of water testing be retained according to the Oregon Health Services requirements.

(2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment will be kept in good repair, clean, neat and orderly.

(3) Plumbing Fixtures. Each bathtub, shower, lavatory, and toilet will be kept clean, in good repair and regularly sanitized.

(4) Disposal of Cleaning Waste Water. No kitchen sink, lavatory, bathtub, or shower will be used for the disposal of cleaning waste water.

(5) Soiled Laundry. Soiled linens and clothing will be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.

(6) Pest Control. All necessary measures will be taken to prevent rodents and insects from entering the facility. Should pests be found in the facility, appropriate action will be taken to eliminate them.

(7) Grounds Maintenance. The grounds of the facility will be kept orderly and reasonably free of litter, unused articles, and refuse.

(8) Garbage Storage and Removal. Garbage and refuse receptacles will be clean, durable, watertight, insect and rodent proof, and will be kept covered with tight-fitting lids. All garbage and solid waste will be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.

(9) Sewage Disposal. All sewage and liquid wastes will be disposed of in a municipal sewage system where such facilities are available. If a municipal sewage system is not available, sewage and liquid wastes will be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality. Sewage lines, and septic tanks or other non-municipal sewage disposal systems where applicable, will be maintained in good working order.

(10) Biohazardous Waste. Biohazardous waste will be disposed of in compliance with the rules of the Department of Environmental Quality.

(11) Infection Control. Precautions will be taken to prevent the spread of infectious and/or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards. In accordance with OAR 437, division 2, Subdivision Z, Section 1910.1030 of the Oregon Occupational Safety and Health Code, staff will employ universal precautions whereby all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

(12) Infection Control for Pets and Other Household Animals. If pets or other household animals exist at a facility, sanitation practices will be implemented to prevent health hazards.

(a) Such animals will be vaccinated in accordance with the recommendations of a licensed veterinarian. Proof of such vaccinations will be maintained on the premises.

(b) Animals not confined in enclosures will be under control and maintained in a manner that does not adversely impact residents or others.

(c) No live animal will be kept or allowed in any portion of the premises where food is stored or prepared, except that aquariums and aviaries will be allowed if enclosed so as not to create a public health problem.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0140
Resident Furnishings

(1) Bedroom Furniture. Residents will be allowed to use their own furniture within space limitations of the resident sleeping room. Otherwise, furniture will be provided or arranged for each resident, maintained in good repair and include:

(a) A bed, including a frame and a clean mattress and pillow;

(b) A private dresser or similar storage area for personal belongings which is readily accessible to the resident; and

(c) Locked storage for the resident's small, personal belongings. In facilities initially licensed before June 1, 1998, this locked storage may be provided in a place other than the resident's bedroom. The resident will be provided with a key or other method to gain access to his/her locked storage space.

(2) Linens. Linens will be provided for each resident and will include:

(a) Sheets, pillowcase, other bedding appropriate to the season and individual resident's comfort;

(b) Availability of a waterproof mattress or waterproof mattress cover; and

(c) Towels and washcloths.

(3) Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, and menstrual supplies (if needed).

(4) Supplies Provided by Facility. Sufficient supplies of soap, shampoo and toilet paper for all residents will be provided.

(5) Common Area Furniture. An adequate supply of furniture for resident use in living room, dining room and other common areas will be maintained in good condition.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0145
Admission to Facility

(1) Responsibility for Admission Process. Each facility's admission policy and procedures will specify who is responsible for each component of the admission information-gathering and decision-making process. Responsibilities will be organized and assigned to promote effective processing of referrals and admissions.

(2) Referrals. Unless limited by contractual agreement with the Department or other Department-approved party, referrals may be accepted from a variety of sources. Residents whose services will be funded by the Department must be approved for placement by the CMHP or other local entity given responsibility for this function by contract with the Department, and/or the Department.

(3) Release of Information. In accordance with ORS 179.505 and the 45 Code of Federal Registry, Part 164, an authorization for the release of information will be obtained for any confidential information concerning a prospective resident.

(4) Nondiscrimination. Persons will be considered for admission without regard to race, color, sex or sexual orientation (except as may be limited by room arrangement), religion, creed, national origin, age (except under 18 years), familial status, marital status, source of income, or disability in addition to the mental or emotional disorder.

(5) Screening. Prior to accepting a resident for admission to the facility, the administrator or his/her designee will determine that the resident meets admission criteria. The prospective resident will receive an explanation of the program, be given a copy of materials explaining conditions of residency, and be offered the opportunity to visit the facility. Sufficient information will be obtained from the prospective resident, a relative and/or agencies providing services to determine eligibility for admission and service needs. In the case of individuals referred for emergency or crisis-respite admission, the information obtained may be less extensive than for regular admissions but must be sufficient to determine that the resident meets admission criteria and that the facility is appropriate considering the individual's needs. Screening information will include, but not be limited to, the following:

(a) Written documentation that the prospective resident has, or is suspected of having, a mental or emotional disorder;

(b) Background information including a mental health assessment and describing previous living arrangements, service history, behavioral issues and service needs;

(c) Medical information including a brief history of any health conditions, documentation from a Licensed Medical Professional or other qualified health care professional of the individual's current physical condition, and a written record of any current or recommended medications, treatments, dietary specifications, and aids to physical functioning;

(d) Copies of documents, or other documentation, relating to guardianship, conservatorship, commitment status, advance directives, or any other legal restrictions (as applicable);

(e) A copy of the prospective resident's most recent mental health treatment plan, or in the case of an emergency or crisis-respite admission, a summary of current mental health treatment involvement; and

(f) Documentation of the prospective resident's ability to evacuate the building consistent with the facility's designated evacuation capability and other concerns about potential safety risks.

(6) Admission Criteria. Persons considered for admission will:

(a) Be assessed to have a mental or emotional disorder, or a suspected mental or emotional disorder;

(b) Be in need of care, treatment and supervision;

(c) Be at least 18 years of age;

(d) Not require continuous nursing care, unless a reasonable plan to provide such care exists, the need for residential treatment supersedes the need for nursing care, and the Department approves the placement;

(e) Have an evacuation capability consistent with the facility's SR Occupancy classification; and

(f) Meet additional criteria required or approved by the Department through contractual agreement or condition of licensing.

(7) Admission Decisions. An admission decision will be made based upon the existence of an opening within the facility, a review of screening materials at a pre-admission meeting and a determination that the resident meets the admission criteria. A pre-admission meeting will be scheduled to include the facility administrator or designee, the potential resident and his/her legal guardian (as applicable). With the prospective resident's consent, the pre-admission meeting may also include family member(s) or other representative(s) as appropriate, representative(s) of relevant service providing agencies, and others with an interest in the resident's admission. Potential residents, their legal guardian (as applicable) and authorized representative will be informed of admission decisions within 72 hours. When admission is denied, the prospective applicant, their legal guardian (as applicable) and authorized representative will be informed in writing of the basis for the decision and their right to appeal the decision in accordance with OAR 309-035-0157.

(8) Informed Consent for Services. Each resident, or his/her guardian (as applicable), will provide informed consent for services upon admission to the facility, unless the resident's ability to do so is legally restricted.

(9) Orientation. Upon admission, the administrator or his/her designee will provide an orientation to each new resident that includes, but is not limited to, a complete tour of the facility, introductions to other residents and staff, discussion of house rules, explanation of the laundry and food service schedule and policies, review of resident rights and grievance procedures, explanation of the fee policy, discussion of the conditions under which residency would be terminated, and a general description of available services and activities. During the orientation, advance directives will be explained. If the resident does not already have any advance directive(s), she/he will be given an opportunity to complete them. Orientation will also include a description of the facility's emergency procedures in accordance with OAR 309-035-0130(2).

(10) Record Preparation. A resident record will be established concurrent with the resident's admission. Prior to admission, within five days after an emergency admission, or within 24 hours of a crisis-respite admission, the facility will determine with whom communication needs to occur and will attempt to obtain the needed authorizations for release of information. The record established upon admission will include the materials reviewed in screening the resident, the summary sheet and any other available information. Every effort will be made to complete the resident record consistent with OAR 309-035-0117(4) in a timely manner. The assessment and residential service plan will be completed in accordance with OAR 309-035-0159. Records on prescribed medications and health needs will be completed as specified in OAR 309-035-0170.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0150
Termination of Residency

(1) Responsibility for Termination Process. Each facility's termination policy and procedures will specify who is responsible for each step of the process for terminating residency. Responsibilities will be organized and assigned to promote a fair and efficient termination process. Unless otherwise designated as a condition of licensing or in contract language approved by the Department, the Administrator will be responsible for initiating and coordinating termination proceedings. An effort will be made to prevent unnecessary terminations by making reasonable accommodations within the facility.

(2) Voluntary Termination of Residency. A resident or guardian (as applicable) may terminate residency in a facility upon providing at least 30 days notice. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided.

(3) Emergency Termination of Residency. If a resident's behavior poses a serious and immediate threat to the health or safety of others in or near the facility, the administrator, after providing 24 hours written notice specifying the causes to the resident or guardian (as applicable), may immediately terminate the residency. The notice will specify the resident's right to appeal the emergency termination decision in accordance with OAR 309-035-0157.

(4) Other Terminations of Residency. When other circumstances arise providing grounds for termination of residency, the Administrator will discuss these grounds with the resident, the resident's guardian (as applicable), and with the resident's permission, other persons with an interest in the resident's circumstances. If a decision is made to terminate residency, the Administrator will provide at least 30 days written notice specifying the causes to the resident or guardian (as applicable). This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0157. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided. An effort will be made to establish a reasonable termination date in consideration of both facility needs and the needs of the terminated resident to find alternative living arrangements. Criteria establishing grounds for termination include:

(a) Resident no longer needs or desires services provided at the facility and/or expresses a desire to move to an alternative setting;

(b) Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the facility;

(c) Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the facility or services that can be arranged outside of the facility;

(d) Resident cannot safely evacuate the facility in accordance with the facility's SR Occupancy Classification after efforts described in OAR 309-035-0130(5)(b) have been taken;

(e) Nonpayment of fees in accordance with program's fee policy; and

(f) Resident continuously and knowingly violates house rules resulting in significant disturbance to others.

(5) Pre-termination Meeting. Except in the case of emergency terminations or crisis-respite residents, a pre-termination meeting will be held with the resident, guardian (as applicable), and with the resident's permission, others interested in the resident's circumstances. The purpose of the meeting is to plan any arrangements necessitated by the termination decision. The meeting will be scheduled to occur at least two weeks prior to the termination date. In the event a pre-termination meeting is not held, the reason will be documented in the resident's record.

(6) Documentation. Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record.

(7) Disposition of Personal Property. At the time of termination of residency, the resident will be given a statement of account, any balance of funds held by the facility and all property held in trust or custody by the facility.

(a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the resident will be provided a final financial statement along with any funds due to the resident.

(b) In the case of resident belongings left at the facility for longer than seven days after termination of residency, the RTF will make a reasonable attempt to contact the resident, guardian (as applicable) and/or other representative of the resident. The RTF must allow the resident, guardian (as applicable) or other representative at least 15 days to make arrangements concerning the property. If it is determined that the resident has abandoned the property, the RTF may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the resident, will be forwarded to the resident or guardian (as applicable).

(8) Crisis-respite Services. Because crisis-respite services are time-limited, the planned end of services will not be considered a termination of residency and subject to requirements in OAR 309-035-0150(2), (4) and (5). Upon admission to crisis-respite services, the resident or guardian (as applicable) will be informed of the planned date for discontinuation of services. This date may be extended through mutual agreement between the administrator and the resident or guardian (as applicable). RTFs providing crisis-respite services will implement policies and procedures that specify reasonable time frames and the grounds for discontinuing crisis-respite services earlier than the date planned.

(9) Absences without Notice. If a resident moves out of the facility without providing notice, or is absent without notice for more than seven consecutive days, the administrator may terminate residency in the manner provided in ORS 105.105 to 105.168 after seven consecutive days of the resident's absence. An attempt will be made to contact the resident, guardian (as applicable) and/or other person interested in the resident's circumstances to confirm the resident's intent to discontinue residency.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0155
Resident Rights

(1) Statutory and Constitutional Rights. Each resident will be assured the same civil and human rights accorded to other citizens. These rights will be assured unless expressly limited by a court in the case of a resident who has been adjudicated incompetent and not restored to legal capacity. The rights described in paragraphs (2) and (3) of this section are in addition to, and do not limit, all other statutory and constitutional rights which are afforded to all citizens including, but not limited to, the right to vote, marry, have or not have children, own and dispose property, enter into contracts and execute documents.

(2) Rights of Service Recipients. In accordance with ORS 430.210, residents will have the right to:

(a) Choose from available services those which are appropriate, consistent with the plan developed in accordance with paragraphs (b) and (c) of this subsection, and provided in a setting and under conditions that are least restrictive to the person's liberty, that are least intrusive to the person and that provide for the greatest degree of independence;

(b) An individualized written service plan, services based upon that plan and periodic review and reassessment of service needs;

(c) Ongoing participation in planning services in a manner appropriate to the person's capabilities, including the right to participate in the development and periodic revision of the plan described in paragraph (b) of this subsection, and the right to be provided with a reasonable explanation of all service considerations;

(d) Not receive services without informed consent except in a medical emergency or as otherwise permitted by law;

(e) Not participate in experimentation without informed voluntary written consent;

(f) Receive medication only for the person's individual clinical needs;

(g) Not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure;

(h) A humane service environment that affords reasonable protection from harm and affords reasonable privacy;

(i) Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;

(j) Religious freedom;

(k) Not be required to perform labor, except personal housekeeping duties, without reasonable and lawful compensation;

(l) Visit with family members, friends, advocates and legal and medical professionals;

(m) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Department;

(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this section and the procedure for reporting abuse, and to have these rights and procedures prominently posted in a location readily accessible to the person and made available to the person's guardian and any representative designated by the person;

(o) Assert grievances with respect to infringement of the rights described in this section, including the right to have such grievances considered in a fair, timely and impartial grievance procedure;

(p) Have access to and communicate privately with any public or private rights protection program or rights advocate; and

(q) Exercise all rights described in this section without any form of reprisal or punishment.

(3) Additional Rights in Residential Treatment Facilities. Residents will also have a right to:

(a) Adequate food, shelter and clothing, consistent with OAR 309-035-0159;

(b) A reasonable accommodation if, due to their disability, the housing and services are not sufficiently accessible;

(c) Confidential communication, including receiving and opening personal mail, private visits with family members and other guests, and access to a telephone with privacy for making and receiving telephone calls;

(d) Express sexuality in a socially appropriate and consensual manner;

(e) Access to community resources including recreation, religious services, agency services, employment and day programs, unless such access is legally restricted;

(f) Be free from seclusion and restraint, except as outlined in OAR 309-035-0167.

(g) To review the Residential Treatment Facility's policies and procedures; and

(h) Not participate in research without informed voluntary written consent.

(4) Program Requirements. The program will have and implement written policies and procedures which protect residents' rights, and encourage and assist residents to understand and exercise their rights. The program will post a listing of resident rights under these rules in a place readily accessible to all residents and visitors.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0157
Grievances and Appeals

(1) Procedures. The facility will have a written policy and procedures concerning the resident grievance and appeal process. A copy of the grievance and appeal process will be posted in a place readily accessible to residents. A copy of the grievance and appeal process will be provided to each resident and guardian (as applicable) at the time of admission to the facility.

(2) Grievances. A facility's process for grievances must, at a minimum, include the following:

(a) Residents will be encouraged to informally resolve complaints through discussion with RTF staff.

(b) If the resident is not satisfied with the informal process or does not wish to use it, the resident may proceed as follows:

(A) The resident may submit a complaint in writing to the RTF Administrator. The resident may receive assistance in submitting the complaint from any person whom the resident chooses. If requested by the resident, RTF staff will be available to assist the resident.

(B) The written complaint will go directly to the RTF Administrator without being read by other staff, unless the resident requests or permits other staff to read the complaint.

(C) The complaint will include the reasons for the grievance and the proposed resolutions. No complaint will be disregarded because it is incomplete.

(D) Within five days of receipt of the complaint, the RTF Administrator will meet with the resident to discuss the complaint. The res-

ident may have an advocate or other person of his/her choosing present for this discussion.

(E) Within five days of meeting with the resident, the RTF Administrator will provide a written response to the resident. As part of the written response, the Administrator will provide information about the appeal process.

(F) In circumstances where the matter of the complaint is likely to cause irreparable harm to a substantial right of the resident before the grievance procedures outlined in OAR 309-035-0157(2)(b)(D) and (E) are completed, the resident may request an expedited review. The RTF Administrator will review and respond in writing to the grievance within 48 hours. The written response will include information about the appeal process.

(3) Appeals. Residents, their legal guardians (as applicable) and prospective residents (as applicable) will have the right to appeal admission, termination and grievance decisions as follows:

(a) If the resident is not satisfied with the decision, the resident may file an appeal in writing within ten days of the date of the RTF Administrator's response to the complaint or notification of admission denial or termination (as applicable). The appeal will be submitted to the CMHP Director or designee in the county where the RTF is located.

(b) The resident may receive assistance in submitting the appeal. If requested by the resident, RTF staff will be available to assist the resident.

(c) The CMHP Director or designee will provide a written response within ten days of receiving the appeal.

(d) If the resident is not satisfied with the CMHP Director's decision, the resident may file a second appeal in writing within ten days of the date of the CMHP Director's written response to the Administrator of the Department or designee. The decision of the Administrator of the Department will be final.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0159
Resident Assessment and Residential Service Plan

(1) Assessment. An assessment will be completed for each resident within 30 days after admission to the facility, unless admitted to the facility for crisis-respite services.

(a) The assessment will be based upon an interview with the resident to identify strengths, preferences and service needs; observation of the resident's capabilities within the residential setting; a review of information in the resident record; and contact with representatives of other involved agencies, family members and others, as appropriate. All contacts with others will be made with proper authorization for the release of information.

(b) Assessment findings will be summarized in writing and included in the resident's record. Assessment findings will include, but not be limited to, diagnostic and demographic data; identification of the resident's medical, physical, emotional, behavioral and social strengths, preferences and needs related to independent living and community functioning; and recommendations for residential service plan goals.

(2) Residential Service Plan. An individualized plan, identifying the goals to be accomplished through the services provided, will be prepared for each resident, unless admitted to the facility for crisis-respite services, within 30 days after admission.

(a) The residential service plan will be based upon the findings of the resident assessment, be developed with participation of the resident and his/her guardian (as applicable), and be developed through collaboration with the resident's primary mental health treatment provider. With consent of the resident or guardian (as applicable), family members, representatives from involved agencies, and others with an interest in the resident's circumstances will be invited to participate. All contacts with others will be made with proper, prior authorization from the resident.

(b) The residential service plan will identify service needs, desired outcomes and service strategies to address, but not be limited to, the following areas: physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability and community navigation.

(c) The residential service plan will be signed by the resident, the administrator or other designated facility staff person, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan.

(3) Crisis-respite Requirements. For residents admitted to facilities for 30 days or less, an assessment and residential service plan must be developed within 48 hours of admission which identifies service needs, desired outcomes and the service strategies to be implemented to resolve the crisis or address other needs of the individual that resulted in the short term service arrangement.

(4) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes identified in the residential service plan. A progress note will be entered in the resident's record at least once each month.

(5) Re-assessments and Revisions to the Residential Service Plan. The assessment and residential service plan will be reviewed and updated at least annually. On an ongoing basis, the residential service plan will be updated, as necessary, based upon changing circumstances or upon the resident's request for reconsideration.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0165
Resident Services and Activities

(1) General Requirements. The services and activities available at the facility will include care and treatment consistent with ORS 443.400 and those services individually specified for the resident in the residential service plan developed as outlined in OAR 309-035-0159. Residents will be encouraged to care for their own needs to the extent possible. All services and activities will be provided in a manner that respects residents' rights, promotes recovery and affords personal dignity.

(2) Services and Activities to Be Available. Services and activities to be available will include but not be limited to:

(a) Provision of adequate shelter consistent with OAR 309-035-0125 through 309-035-0140;

(b) At least three meals per day, seven days per week, provided in accordance with OAR 309-035-0170;

(c) Assistance and support, as necessary, to enable residents to meet personal hygiene and clothing needs;

(d) Laundry services, which may include access to washer(s) and dryer(s) so residents can do their own personal laundry;

(e) Housekeeping essential to the health and comfort of residents;

(f) Activities and opportunities for socialization and recreation both within the facility and in the larger community;

(g) Health-related services provided in accordance with OAR 309-035-0175;

(h) Assistance with community navigation and transportation arrangements;

(i) Assistance with money management, where requested by a resident, to include accurate documentation of all funds deposited and withdrawn when funds are held in trust for the resident;

(j) Assistance with acquiring skills to live as independently as possible;

(k) Assistance with accessing other additional services, as needed; and

(l) Any additional services required under contract the Department.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0167
Use of Seclusion or Restraints

(1) General Prohibition. The use of seclusion or restraints is prohibited, except in Secure Residential Treatment Facilities with the Department's approval.

(2) Approval of Use in Secure Residential Treatment Facilities. A Secure Residential Treatment Facility provider or applicant may submit an application to the Department for approval to use seclusion or restraints pursuant to OAR 309-033-0700 through 309-033-0740. Approval by the Department will be based upon the following:

(a) A determination that the residents served, or proposed to be served, have a history of behavioral concerns involving threats to the safety and well-being of themselves or others;

(b) The applicant demonstrates that the availability of seclusion or restraints is necessary to safely accommodate persons who would otherwise be unable to experience a community residential program; and

(c) The applicant demonstrates an ability to comply with OAR 309-033-0700 through 309-033-0740 and 309-033-0500 through 309-033-0560. These rules include special requirements for staffing, training, reporting, policies and procedures, and the facility's physical environment.

(3) Conditions of Use. Seclusion or restraints will only be used in approved Secure Residential Treatment Facilities when an emergency occurs in accordance with OAR 309-033-0700 through 309-033-0740 and 309-033-0500 through 309-033-0560. In such emergency situations, seclusion and restraint will be used as a last resort behavior management option after less restrictive behavior management interventions have failed, or in the case of an unanticipated behavioral outburst, to insure safety within the facility. Approved Secure Residential Treatment Facilities will implement policies and procedures approved by the Department outlining the circumstances under which seclusion or restraints would be used and the preventive measures to be taken before such use. All incidents involving the use of seclusion or restraints will be reported to the Department. In order to use seclusion or restraints with a resident who is not in state custody under civil commitment proceedings, the resident must be placed on a hold.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0170
Food Services

(1) Well-balanced Diet. Meals will be planned and served in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid.

(2) Modified or Special Diets. An order from a Licensed Medical Professional will be obtained for each resident who, for health reasons, is on a modified or special diet. Such diets will be planned in consultation with the resident.

(3) Menus. Menus will be prepared at least one week in advance and will provide a sufficient variety of foods served in adequate amounts for each resident at each meal and adjusted for seasonal changes. Records of menus, as served, will be filed and maintained in the facility for at least 30 days. Resident preferences and requests will be considered in menu planning. Religious and vegetarian preferences will be reasonably accommodated.

(4) Supply of Food. Adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days will be maintained on the premises.

(5) Sanitation. Food will be stored, prepared and served in accordance with Health Services Food Sanitation Rules.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0175
Health Services

(1) General. The administrator will be responsible for assuring that all residents are offered medical attention when needed. Arrangements for health services will be made with the informed consent of the resident and/or guardian (as applicable). The RTF will arrange for physicians or other qualified health care professionals to be available in the event the resident's regular physician or other health care professional is unavailable. A hospital emergency room will be identified and may be used in case of emergency.

(2) Initial Health Screening. Each resident admitted to the facility will be screened by a Licensed Medical Professional or other qualified health care professional to identify health problems and to screen for communicable disease. Documentation of the initial health screening will be placed in the resident record.

(a) The health screening will include a brief history of health conditions, current physical condition and a written record of current or recommended medications, treatments, dietary specifications and aids to physical functioning.

(b) For regular admissions, the health screening will be obtained prior to the resident's admission and include the results of testing for tuberculosis and Hepatitis B.

(c) For emergency admissions, including crisis-respite admissions, the health screening will be obtained as follows:

(A) For individuals experiencing psychiatric or medical distress, a health screening will be completed by a Licensed Medical Professional or other qualified health care professional prior to the resident's admission or within 24 hours of the emergency placement. The health screening will confirm that the individual does not have health conditions requiring continuous nursing care, a hospital level of care, or immediate medical assistance. For each crisis-respite resident who continues in the facility for more than seven consecutive days, a complete health examination will be arranged if any symptoms of a health concern exist.

(B) For other individuals who are admitted on an urgent basis due to a lack of alternative supportive housing, the health screening will be obtained within 72 hours after the resident's admission.

(C) The health screening criteria may be waived for individuals admitted for crisis-respite services who are under the active care of an LMP or other qualified health care professional if it is the opinion of the attending health care professional that the crisis-respite placement presents no health risk to the individual or other residents in the facility. Such a waiver must be provided in writing and be signed and dated by the attending health care professional within 24 hours of the resident's admission.

(3) Regular Health Examinations. Except for crisis-respite residents, the program will insure that each resident has a primary physician or other qualified health care professional who is responsible for monitoring his/her health care. Regular health examinations will be done in accordance with the recommendations of this primary health care professional, but not less than once every three years. New residents will have a health examination completed within one year prior to admission or within three months after admission. Documentation of findings from each examination will be placed in the resident's record.

(4) Written Orders for Special Needs. A written order, signed by a physician or other qualified health care professional, is required for any medical treatment, special diet for health reasons, aid to physical functioning or limitation of activity.

(5) Medications. A written order signed by a physician or other qualified health care professional is required for all medications administered or supervised by RTF staff. This written order is required before any medication is provided to a resident. Medication will not be used for the convenience of staff or as a substitute for programming. Medications will not be withheld or used as reinforcement or punishment, or in quantities that are excessive in relation to the amount needed to attain the client's best possible functioning.

(a) Medications will be self-administered by the resident if the resident demonstrates the ability to self-administer medications in a safe and reliable manner. In the case of self-administration, both the written orders of the prescriber and the residential service plan will document that medications will be self-administered. The self-administration of medications may be supervised by facility staff who may prompt the resident to administer the medication and observe the fact of administration and dosage taken. When supervision occurs, staff will enter information in the resident's record consistent with section (5)(h) below.

(b) Staff who assist with administration of medication will be trained by a Licensed Medical Professional on the use and effects of commonly used medications.

(c) Medications prescribed for one resident will not be administered to, or self-administered by, another resident.

(d) Stock supplies of prescription medications will not be maintained. The facility may maintain a stock supply of non-prescription medications.

(e) The facility will provide and implement a policy and procedure which assures that all orders for prescription drugs are reviewed by a qualified health care professional, as specified by a physician or other qualified health care professional but not less often than every six months. Where this review identifies a contra-indication or other concern, the resident's primary physician, LMP or other primary health care professional will be immediately notified. Each client receiving psychotropic medications will be evaluated at least every three months by the LMP prescribing the medication, who will note, for the resident's record, the results of the evaluation and any changes in the type and dosage of medication, the condition for which it is prescribed,

when and how the medication is to be administered, common side effects (including any signs of tardive dyskinesia, contraindications or possible allergic reactions), and what to do in case of a missed dose or other dosing error.

(f) All unused, discontinued, outdated or recalled medications, and any medication containers with worn, illegible or missing labels will be disposed. The method of disposal will be safe, consistent with any applicable federal statutes, and designed to prevent diversion of these substances to persons for whom they were not prescribed. A written record of all disposals will be maintained and specify the date of disposal, a description of the medication, its dosage potency, amount disposed, the name of the individual for whom the medication was prescribed, the reason for disposal, the method of disposal, and the signature of the staff person disposing the medication. For any medication classified as a controlled substance in schedules 1 through 5 of the Federal Controlled Substance Act, the disposal must be witnessed by a second staff person who documents their observation by signing the disposal record.

(g) All medications will be properly and securely stored in a locked space for medications only in accordance with the instructions provided by the prescriber or pharmacy. Medications for all residents will be labeled. Medications requiring refrigeration must be stored in an enclosed locked container within the refrigerator. The facility will assure that residents have access to a locked, secure storage space for their self-administered medications. The facility will note in its written policy and procedures which persons have access to this locked storage and under what conditions.

(h) For all residents taking prescribed medication, staff will record in the medical record each type, date, time and dose of medication provided. All effects, adverse reactions and medications errors will be documented in the resident's record. All errors, adverse reactions or refusals of medication will be reported to the prescribing professional within 48 hours.

(i) P.r.n. medications and treatments will only be administered in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

(6) Delegation of Nursing Tasks. Nursing tasks may be delegated by a Registered Nurse to direct care staff within the limitations of their classification and only in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0185
Civil Penalties

(1) Applicability of Long Term Care Statute. For purposes of imposing civil penalties, residential treatment facilities licensed under ORS 443.400 to 443.455 and subsection (2) of ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) Sections of Rule Subject to Civil Penalties. Violations of any requirement within any part of the following sections of the rule may result in a civil penalty:

(a) 309-035-0110 Licensing;
(b) 309-035-0113 Contracts and Rates;
(c) 309-035-0115 Administrative Management;
(d) 309-035-0117 Records;
(e) 309-035-0120 Staffing;
(f) 309-035-0125 Facility Requirements;
(g) 309-035-0130 Safety;
(h) 309-035-0135 Sanitation;
(i) 309-035-0140 Resident Furnishings;
(j) 309-035-0145 Admission to Facility;
(k) 309-035-0150 Termination of Residency;
(l) 309-035-0155 Resident Rights;
(m) 309-035-0157 Grievances and Appeals;
(n) 309-035-0159 Resident Assessment and Residential Service Plan;
(o) 309-035-0165 Resident Services and Activities;
(p) 309-035-0167 Use of Seclusion or Restraints;
(q) 309-035-0170 Food Services; and
(r) 309-035-0175 Health Services.

(3) Assessment of Civil Penalties. Civil penalties will be assessed in accordance with the following guidelines:

(a) Civil penalties, not to exceed $250 per violation to a maximum of $1,000, may be assessed for general violations of these rules. Such penalties will be assessed after the procedures outlined in OAR 309-035-0110(8) have been implemented;

(b) A mandatory penalty up to $500 will be assessed for falsifying resident or facility records or causing another to do so;

(c) A mandatory penalty of $250 per occurrence will be imposed for failure to have direct care staff on duty 24 hours per day;

(d) Civil penalties up to $1,000 per occurrence may be assessed for substantiated abuse;

(e) In addition to any other liability or penalty provided by the law, the Department may impose a penalty for any of the following:

(A) Operating the RTF without a license;

(B) Operating with more residents than the licensed capacity; and

(C) Retaliating or discriminating against a resident, family member, employee, or other person for making a complaint against the program.

(f) In imposing a civil penalty, the following factors will be taken into consideration:

(A) The past history of the person incurring the penalty in taking all feasible steps or procedures to correct the violation;

(B) Any prior violations of statutes, rules or orders pertaining to the facility;

(C) The economic and financial conditions of the person incurring the penalty;

(D) The immediacy and extent to which the violation threatens or threatened the health, safety or welfare of one or more residents; and

(E) The degree of harm caused to residents.

(4) Notification. Any civil penalty imposed under this section will become due and payable ten days after notice is received, unless a request for a hearing is filed. The notice will be delivered in person, or sent by registered or certified mail and will include a reference to the particular section of the statute or rule involved, a brief summary of the violation, the amount of the penalty or penalties imposed, and a statement of the right to request a hearing.

(5) Request for Hearing. The person to whom the notice is addressed will have ten days from the date of receipt of the notice to request a hearing. This request must be in writing and submitted to the Administrator of the Department. If the written request for a hearing is not received on time, the Department will issue a final order by default.

(6) Hearings. All hearings will be conducted pursuant to the applicable provisions of ORS 183.310 and 183.400 to 183.502, Administrative Procedure and Rules for Civil Penalties.

(7) Judgment. Unless the penalty is paid within ten days after the order becomes final, the order constitutes a judgment and may be recorded by the County Clerk which becomes a lien upon the title to any interest in real property owned by the person. The Department may also take action to revoke the license upon failure to comply with a final order.

(8) Judicial Review. Civil penalties are subject to judicial review under ORS 183.480, except that the court may, at its discretion, reduce the amount of the penalty.

(9) Disposition of Funds. All penalties recovered under ORS 443.790 to 443.815 will be paid into the State Treasury and credited to the General Fund.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

309-035-0190
Criminal Penalties

(1) Specification of Criminal Penalty. Violation of any provision of ORS 443.400 through 443.455 is a Class B misdemeanor.

(2) Grounds for Law Suit. In addition, the Department may commence an action to enjoin operation of a residential treatment facility:

(a) When a residential treatment facility is operated without a valid license; or

(b) When a residential treatment facility continues to operate after notice of revocation has been given and a reasonable time has been allowed for placement of residents in other facilities.

Stat. Auth.: ORS 409.010 & 443.450

Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 9-1984(Temp), f. & ef. 12-10-84; MHD 9-1985, f. & ef. 6-7-85; MHD 4-1998, f. 5-21-98, cert. ef. 6-1-98; MHD 4-2005, f. & cert. ef. 4-1-05

Residential Treatment Homes

309-035-0250
Purpose, Scope and Statutory Authority

(1) Purpose. These rules prescribe standards by which the Office of Mental Health and Addiction Services (OMHAS) approves residential treatment homes for adults with mental or emotional disorders. The standards promote the well-being, health and recovery of adults with mental or emotional disorders through the availability of a wide range of residential service options. They prescribe how services will be provided in safe, secure and homelike environments that recognize the dignity, individuality and right to self-determination of each resident.

(2) Scope. These rules apply to residential treatment homes for five or fewer residents.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0260
Definitions

As used in these rules the following definitions apply:

(1) "Abuse" includes but is not limited to:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or provider, or other caregiver and the adult. For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

(e) Neglect that leads to physical harm or significant mental injury through withholding of services necessary to maintain health and well being;

(f) Abuse does not include spiritual treatments by a duly accredited practitioner of a recognized church or religious denomination when voluntarily consented to by the adult.

(g) Abuse also includes:

(A) Failure to act and/or neglect that results in imminent danger of causing physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to failure by a provider or staff to provide an adult with adequate food, clothing, shelter, medical care, supervision, or through tolerating or permitting abusive conduct toward an adult by any other person. However, no person will be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment;

(B) Verbal mistreatment by subjecting an adult to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation and threatening injury or withholding of services or supports, including implied or direct threat of termination of services;

(C) Placement of restrictions on a resident's freedom of movement. Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan;

(D) Financial exploitation by a caregiver including, but not limited to, unauthorized rate increases, borrowing from or loaning money to residents, witnessing wills in which a caregiver is beneficiary, adding caregiver's name to resident's bank accounts or other personal property without approval of the resident or his/her guardian or conservator and the PCP team; and

(E) Inappropriate expenditure of a resident's personal funds, theft of a resident's personal funds, use of a resident's personal funds for caregivers own benefit, commingling of a resident's funds with caregiver or other resident's funds, or a caregiver becoming guardian or conservator.

(2) "Administrator" means the person designated by the licensee as responsible for the daily operation and maintenance of the RTH.

(3) "Adult" means an individual 18 years of age or older.

(4) "Aid to Physical Functioning" means any special equipment ordered for a resident by a Licensed Medical Professional or other qualified health care professional which maintains or enhances the resident's physical functioning.

(5) "Applicant" means the person(s) or entity that owns the business and is applying for the license.

(6) "Approved" means authorized or allowed by the Department.

(7) "Building Code" means the state building code as defined in ORS 455.010 and includes the **Oregon Structural Specialty Code**, **One** and **Two Family Dwelling Code** and other specialty codes adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(8) "Care" means services such as supervision; protection; assistance with activities of daily living such as bathing, dressing, grooming, or eating; management of money; transportation; recreation; and the providing of room and board.

(9) "Community Mental Health Program (CMHP)" means the organization of all or a portion of services for persons with mental or emotional disorders, and developmental disabilities operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Office of Mental Health and Addiction Services Department.

(10) "Contract" means a formal written agreement between the community mental health program, Mental Health Organization or the Office of Mental Health and Addiction Services Department and a residential treatment home owner.

(11) "Crisis-Respite Services" means the provision of services to individuals for up to 30 days. Individuals receiving crisis-respite services are RTH residents.

(12) "DSM" means the "Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)" published by the American Psychiatric Association.

(13) "Department" means the Office of Mental Health and Addiction Services (OMHAS) of the Oregon Department of Human Services.

(14) "Direct Care Staff Person" means an employee responsible for providing services to residents.

(15) "Electrical Code" means the Uniform Building and Fire Codes adopted on October 1, 2004 by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(16) "Emergency Admission" means an admission to an RTH made on an urgent basis due to the pressing service needs of the individual.

(17) "Evacuation Capability" means the ability of occupants, including residents and staff as a group, to either evacuate the building or relocate from a point of occupancy to a point of safety as defined for SR Occupancies in the Uniform Building and Fire Codes adopted on October 1, 2004. The category of evacuation capability is determined by documented evacuation drill times or scores on the worksheet for rating residents in Group SR Occupancies in NFPA 101A. There are three categories of evacuation capability:

(a) Impractical (SR- 2): A group, even with staff assistance, that cannot reliably move to a point of safety in a timely manner, determined by an evacuation capability score of five or greater or with evacuation drill times in excess of 13 minutes.

(b) Slow (SR- 1) for more than 16 residents) and (SR-4 for 6 to 16 residents): A group that can move to a point of safety in a timely manner, determined by an evacuation capability score greater than 1.5 and less than five or with evacuation drill times over three minutes but not in excess of 13 minutes. SR-3 occupancies are those homes with five or fewer occupants having evacuation capabilities of impractical or slow with assistance.

(c) Prompt: A group with an evacuation capability score of 1.5 or less or equivalent to that of the general population or with evacuation drill times of three minutes or less. OMHAS is authorized to determine evacuation capability for RTFs in accordance with the **National Fire Protection Association** (NFPA) **101A 2000 edition**. Facilities that are determined to be "Prompt" may be used in Group R occupancies classified by the building official, in accordance with the building code.

(18) "Fire Code" means the **Oregon Fire Code** as adopted by the Office of State Fire Marshal and as amended by local jurisdictions.

(19) "Home" means the building and grounds where the residential treatment home program is operated.

(20) "Licensed Medical Professional (LMP)" means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(a) Holds at least one of the following educational degrees and valid licensures:

(A) Physician licensed to practice in the State of Oregon;

(B) Nurse Practitioner licensed to practice in the State of Oregon; or

(C) Physician's Assistant licensed to practice in the State of Oregon; and

(b) Whose training, experience, and competence demonstrates the ability to conduct a Comprehensive Mental Health Assessment and provide medication management.

(21) "Licensee" means the person(s) or entity legally responsible for the operation of the RTH to which the Department has issued a license.

(22) "Local Mental Health Authority (LMHA)" means the county court or board of county commissioners of one or more counties who choose to operate a CMHP or MHO; or, if the county declines to operate or contract for all or part of a CMHP or MHO, the board of directors of a public or private corporation which contracts with OMHAS to operate a CMHP or MHO for that county.

(23) "Mechanical Code" means the Oregon Mechanical Specialty Code adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(24) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance either internally or externally by any person.

(25) "Mental or Emotional Disorder" means a primary Axis I or Axis II DSM diagnosis, other than mental retardation or a substance abuse disorder, that limits an individual's ability to perform activities of daily living.

(26) "Mental Health Assessment" means a determination by a Qualified Mental Health Professional of the client's need for mental health services. It involves collection and assessment of data pertinent to the client's mental health history and current mental health status obtained through interview, observation, testing, and review of previous treatment records. It concludes with determination of a DSM diagnosis or other justification of priority for mental health services, or a written statement that the person is not in need of community mental health services.

(27) "Mental Health Organization (MHO)" means an approved organization that provides most mental health services through a capitated payment mechanism under the Oregon Health Plan. MHOs can be fully capitated health plans, community mental health programs, private mental health organizations or combinations thereof.

(28) "Nursing Care" means the practice of nursing by a licensed nurse, including tasks and functions that are delegated by a registered nurse to a person other than a licensed nurse, which are governed by ORS Chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR Chapter 851.

(29) "Office of Mental Health and Addiction Services (OMHAS)" means the Department of Human Services (DHS) agency responsible for the administration of state mental health and addiction services in accordance with federal and state laws, rules and regulations. OMHAS may delegate a portion of this responsibility to the CMHPs and MHOs.

(30) "Owner" means the person(s) or entity legally responsible for the operation of the facility.

(31) "Plumbing Code" means the **Oregon Plumbing Specialty Code** adopted by the Building Codes Division of the Oregon Department of Consumer and Business Services.

(32) "P.r.n. (pro re nata) Medications and Treatments" means those medications and treatments that have been ordered to be given as needed.

(33) "Program" means the residential treatment home and may refer to the owner, staff, and/or services as applicable to the context.

(34) "Progress Notes" means the notations in the resident record documenting significant information concerning the resident and summarizing progress made relevant to the objectives outlined in the residential service plan.

(35) "Protection" means the necessary actions taken by the program to prevent abuse or exploitation of the residents, to prevent self-destructive acts, and to safeguard residents, property, and funds.

(36) "Qualified Health Care Professional" means a health care professional licensed to practice in the state of Oregon who is approved to perform certain health care tasks referenced in the relevant section of these rules consistent with the scope of practice specified by the licensing board for the profession. In accordance with the referenced health care task, the qualified health care professional may include a physician, a physician's assistant, a nurse practitioner, a registered nurse, or a pharmacist.

(37) "Qualified Mental Health Professional (QMHP)" means a Licensed Medical Practitioner (LMP) or any other person meeting the following minimum qualifications as documented by the LMHA or designee:

(a) Graduate degree in psychology;

(b) Bachelor's degree in nursing and licensed by the State of Oregon;

(c) Graduate degree in social work;

(d) Graduate degree in behavioral science field;

(e) Graduate degree in recreational, art, or music therapy; or

(f) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(g) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multiaxial DSM diagnosis; write and supervise a Treatment Plan; conduct a Comprehensive Mental Health Assessment; and provide individual, family, and/or group therapy within the scope of his or her practice.

(38) "Resident" means any adult residing in the RTH who receives services on a 24-hour basis, except as excluded under ORS 443.400(3).

(39) "Residential Service Plan" means an individualized, written plan outlining the care and treatment to be provided to a resident in or through the RTH based upon an individual assessment of care and treatment needs. The residential service plan may be a section or subcomponent of the individual's overall plan for mental health treatment when the RTH is operated by a mental health service agency that provides other services to the resident.

(40) "Residential Treatment Home (RTH)" means a home that is operated to provide services on a 24-hour basis for five or fewer residents.

(41) "Restraints" means any chemical or physical methods or devices that are intended to restrict or inhibit the movement, functioning, or behavior of a resident.

(42) "Seclusion" means placing an individual in a locked room. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut.

(43) "Secure Residential Treatment Facility" means any residential treatment facility, or portion thereof, that restricts a resident's exit from the facility or its grounds through the use of approved locking devices on resident exit doors, gates or other closures.

(44) "Services" means the care and treatment provided to residents as part of the RTH program.

(45) "Supervision" means the daily observation, and monitoring of residents by direct care staff or oversight of staff by the administrator or administrator's designee, as applicable to the context.

(46) "Termination of Residency" means the time at which the resident ceases to live in the RTH and includes the transfer of the resident to another facility, but does not include absences from the RTH for the purpose of taking a planned vacation, visiting family or friends, or receiving time-limited medical or psychiatric treatment.

(47) "Treatment" means a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities consistent with ORS 443.400(12).

[Publications: Publications referenced are available from the agency.]

Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHS 13-2007, f. & cert. ef. 8-31-07

309-035-0270
Licensing

(1) License Required. The Department will license any home that meets the definition of a residential treatment home and serves adults with a mental or emotional disorder. In the case of a home serving another category of residents in addition to adults with a mental or emotional disorder, the Department responsible for licensure will be determined by the Director of the Department of Human Services. No person or governmental unit acting individually or jointly with any other person or governmental unit will establish, maintain, manage, or operate a residential treatment home without a license issued by the Department.

(2) Initial Application. An application for a license will be accompanied by the required fee and submitted to the Department using the forms or format required by the Department. The following information will be required in the application:

(a) Full and complete information as to the identity and financial interest of each person, including stockholders, having a direct or indirect ownership interest of five percent or more in the RTH and all officers and directors in the case of RTHs operated or owned by a corporation.

(b) Location (street address) of the home and mailing address;

(c) Maximum number of residents to be served at any one time, their age range and evacuation capability;

(d) Proposed annual budget identifying sources of revenue and expenses;

(e) Signed criminal record authorizations for all persons involved in the operation of the RTH who will have contact with the residents;

(f) A complete set of policies and procedures;

(g) Facility plans and specifications; and

(h) Such other information as the Department may reasonably require.

(3) Plans and Design Approval. A complete set of plans and specifications will be submitted to the Department at the time of initial application, whenever a new structure or addition to an existing structure is proposed, or when significant alterations to an existing facility are proposed. Plans will meet the following criteria:

(a) Plans will be prepared in accordance with the Building Code and requirements of OAR 309-035-0320;

(b) Plans will be to scale and sufficiently complete to allow full review for compliance with these rules; and

(c) Plans will be to scale and carry the stamp of an Oregon licensed architect or engineer when required by the Building Code and ORS Chapters 671 and 672 (laws relating to the practice of architecture and engineering).

(4) Necessary Approvals. Prior to approval of a license for a new or renovated home, the applicant will submit the following to the Department:

(a) One copy of written approval to occupy the home issued by the city, county or state building codes authority having jurisdiction;

(b) One copy of the fire inspection report from the State Fire Marshal or local jurisdiction indicating that the home complies with the Fire Code;

(c) When the home is not served by an approved municipal water system, one copy of the documentation indicating that the state or county health agency having jurisdiction has approved the water supply in accordance with OAR chapter 333, Health Services rules for public water systems.

(d) When the home is not connected to an approved municipal sewer system, one copy of the sewer or septic system approval from the Department of Environmental Quality or local jurisdiction.

(5) Required Fees. The fee for each residential treatment home license application is $30. No fee is required in the case of a governmentally operated residential treatment home.

(6) Renewal Application. A license is renewable upon submission of a renewal application in the form or format required by the Department and a non-refundable fee of $30, except that no fee will be required of a governmentally operated RTH. Filing of an application for renewal before the date of expiration extends the effective date of the current license until the Department takes action upon the renewal application.

(7) Review Process. Upon receipt of an application and fee, the Department will conduct an application review. Initial action by the Department on the application will begin within 30 days of receipt of all application materials. The review will:

(a) Include a complete review of application materials;

(b) Determine whether the applicant meets the qualifications outlined in ORS 443.420 including:

(A) Demonstrates an understanding and acceptance of these rules;

(B) Is mentally and physically capable of providing services for residents;

(C) Employs or utilizes only individuals whose presence does not jeopardize the health, safety, or welfare of residents; and

(D) Provides evidence satisfactory to the Department of financial ability to comply with these rules.

(c) Include a site inspection; and

(d) Conclude with a report stating findings and a decision on licensing of the RTH.

(8) Findings of Noncompliance. The Department will require an owner to submit and complete a plan of correction for each finding of noncompliance with these rules.

(a) If the finding(s) of noncompliance substantially impacts the welfare, health and/or safety of residents, the plan of correction will be submitted and completed prior to issuance of a license. In the case of a currently operating RTH, such findings may result in suspension or revocation of a license.

(b) If it is determined that the finding(s) of noncompliance do not threaten the welfare, health or safety of residents and the facility meets other requirements of licensing, a license may be issued or renewed, and the plan of correction will be submitted and completed as a condition of licensing.

(c) The Department will specify required documentation and set the time lines for the submission and completion of plans of correction in accordance with the severity of the finding(s).

(d) The Department will review and approve each plan of correction. If the plan of correction does not adequately remedy the finding of noncompliance, the Department may require a revised plan of correction.

(e) The RTH owner may appeal the finding of noncompliance or the disapproval of a plan of correction by submitting a request for reconsideration in writing to the Administrator of the Department. The Administrator of the Department or designee will make a decision on the appeal within 30 days of receipt of the appeal.

(9) Variance. The Department may grant a variance to these rules based upon a demonstration by the applicant that an alternative method or different approach provides equal or greater program effectiveness and does not adversely impact the welfare, health or safety of residents.

(a) Variance Application. The RTH owner requesting a variance will submit, in writing, an application to the Department which identifies the section of the rules from which the variance is sought, the reason for the proposed variance, the proposed alternative method or different approach, and signed documentation from the CMHP indicating approval of the proposed variance.

(b) Office of Mental Health and Addiction Services Review. The Assistant Administrator for the Department's Office of Mental Health and Addiction Services, or designee, will review and approve or deny the request for a variance.

(c) Notification of Decision. The Department will notify the RTH owner of the decision in writing within 30 days after receipt of the application. A variance may be implemented only after receipt of written approval from the Department.

(d) Appeal of Decision. The RTH owner may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Administrator of the Department. The Administrator of the Department will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Administrator of the Department will be final.

(e) Duration of the Variance. A variance will be reviewed by the Department at least every two years and may be revoked or suspended based upon a finding that the variance adversely impacts the welfare, health or safety of the RTH residents.

(10) Issuance of License. Upon finding that the applicant is in substantial compliance with these rules, the Department will issue a license.

(a) The license issued will state the name of the owner of the RTH, the name of the administrator, the address of the home to which the license applies, the maximum number of residents to be served at any one time and their evacuation capability, the type of home, and such other information as the Department deems necessary.

(b) A residential treatment home license will be effective for two years from the date issued unless sooner revoked or suspended.

(c) The residential treatment home license is not transferable or applicable to any location, facility, or management other than that indicated on the application and license.

(11) Conditions of License. The license will be valid under the following conditions:

(a) The residential treatment home will not be operated or maintained in combination with a nursing facility, hospital, retirement facility, or other occupancy unless licensed, maintained, and operated as a separate and distinct part. Each residential treatment home will have sleeping, dining and living areas for use only by its own residents, employees and invited guests.

(b) The license will be retained in the home and available for inspection at all times.

(c) Each license will be considered void immediately upon suspension or revocation of the license by the Department, or if the operation is discontinued by voluntary action of the licensee, or if there is a change of ownership.

(12) Site Inspections. Department staff will visit and inspect every residential treatment home at least, but not limited to, once every two years to determine whether it is maintained and operated in accordance with these rules. The RTH owner/applicant will allow Department staff entry and access to the home and residents for the purpose of conducting the inspections.

(a) Department staff will review methods of resident care and treatment, records, the condition of the facility and equipment, and other areas of operation.

(b) All records, unless specifically excluded by law, will be available to the Department for review.

(c) The State Fire Marshal or authorized representative(s) will, upon request, be permitted access to the home, fire safety equipment within the home, safety policies and procedures, maintenance records of fire protection equipment and systems, and records demonstrating the evacuation capability of RTH occupants.

(13) Investigation of Complaints and Alleged Abuse. Incidents of alleged abuse covered by ORS 430.735 through 430.765 will be reported and investigated in accordance with OAR 410-009-0050 through 410-009-0160. Department staff will investigate complaints and other alleged abuse made regarding residential treatment homes, will cause a report to be filed, and will take appropriate action under these rules. The Department may delegate the investigation to a CMHP or other appropriate entity.

(14) Denial, Suspension or Revocation of License. The Department will deny, suspend or revoke a license when it finds there has been substantial failure to comply with these rules; or when the State Fire Marshal or authorized representative certifies that there is a failure to comply with the Fire Code or Building Code.

(a) The Department may immediately suspend a license where there exists an imminent danger to the health or safety of residents.

(A) The Department will provide written notice of the suspension to the licensee citing the violation and stating the corrective action necessary in order for the license to be re-instated.

(B) The licensee may request a review of the decision to immediately suspend a license by submitting a request, in writing, within 10 days of the suspension notice. Within 10 days of receipt of the licensee's request for a review, the Department administrator or designee will review all material relating to the suspension and determine whether to sustain the decision. If the administrator does not sustain the decision, the suspension will be rescinded immediately. The decision of the administrator can be appealed within 90 days as a contested case under ORS 183.310 and 183.400 to 183.502.

(b) The Department will take action to deny or revoke a license in accordance with the following procedures:

(A) The Department will provide written notice of the denial or revocation citing the violation(s), and specifying the effective date (in the case of a currently operating RTH).

(B) The licensee will be entitled to a contested case hearing under ORS 183.310 and 183.400 to 183.502 prior to the effective date of revocation or denial if the licensee requests a hearing in writing, within 21 days after receipt of the written notice. If no such request is received, the decision will be sustained.

(C) A license subject to revocation or denial based upon review of a renewal application, will remain valid during an administrative hearings process, unless suspended, even if the hearing and final order are not issued until after the expiration date of the license.

(D) If an initial license is denied, the applicant will be entitled to a contested case hearing under ORS 183.310 and 183.400 to 183.502 if the applicant requests a hearing in writing within 60 days of receipt of the denial notice. If no such request is received, the decision to deny the license application will be sustained.

(i) In cases where there exists an imminent danger to the health or safety of residents, a license may be suspended immediately.

(ii) Such revocation, suspension, or denial will be done in accordance with rules of the Department under ORS Chapter 183.

(15) Reporting Changes. Each licensee will report promptly to the Department any significant changes to information supplied in the application or subsequent correspondence. Such changes include, but are not limited to, changes in the RTH name, owner entity, administrator, telephone number and mailing address. Such changes also include, but are not limited to, changes in the RTHs physical plant, policies and procedures or staffing pattern when such changes are significant or impact the health, safety or well-being of residents.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0280
Contracts and Rates

(1) Contracts. Residential treatment home operators providing services funded by the Department will enter into a contract with the local community mental health program, the Department or other Department-approved entity. The contract does not guarantee that any number of persons eligible for Department funded services will be referred to or maintained in the home.

(2) Rates. Rates for all services and the procedures for collecting payments from residents and/or payees will be specified in a fee policy and procedures. The fee policy and procedures will describe the schedule of rates, conditions under which rates may be changed, acceptable methods of payment, and the policy on refunds at the time of termination of residency.

(a) For residents whose services are funded by the Department, reimbursement for services will be made according to the rate schedule outlined in the contract. Room and board payments for residents receiving Social Security benefits or public assistance will be in accordance with and not more than rates determined by the Department.

(b) For private paying residents, the program will enter into a signed agreement with the resident, and/or if applicable, resident's guardian, payee or conservator. This agreement will include but not be limited to a description of the services to be provided; the schedule of rates; conditions under which the rates may be changed; and policy on refunds at the time of termination of residency.

(c) Before an RTH increases rates or modifies payment procedures, the program will provide 30 days advance notice of the change to all residents, and their payees, guardians or conservators, as applicable.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0290
Administrative Management

(1) Licensee. The licensee will be responsible for insuring that the RTH is operated in compliance with these rules and all other applicable federal, state and local laws and regulations.

(2) Administrator. The licensee will employ an administrator who:

(a) Has background including special training, experience, and other demonstrated ability in providing care and treatment appropriate to the residents served in the facility;

(b) Has a documented criminal record clearance and no history of abusive behavior;

(c) Will ensure that the RTH operates in accordance with the standards outlined in these rules;

(d) Will oversee the daily operation and maintenance of the RTH and will be available to perform administrative duties at the RTH at least 20 hours per week at the RTH or provide an administrative plan which documents an equivalent level of available supervision.

(e) Will develop and administer written policies and procedures to direct the operation of the RTH and the provision of services to residents;

(f) Will ensure that qualified staff are available, in accordance with the staffing requirements specified in these rules;

(g) Will supervise or provide for the supervision of staff and others involved in the operation of the program;

(h) Will maintain program, personnel and resident records;

(i) Will report regularly to the licensee on the operation of the RTH; and

(j) Will delegate authority and responsibility for the operation and maintenance of the facility to a responsible staff person whenever the Administrator is absent from the RTF. This authority and responsibility will not be delegated to a resident.

(3) Policies and Procedures. Policies and procedures will be developed, updated as necessary, maintained in a location easily accessible for staff reference, and made available to others upon reasonable request. They will be consistent with requirements of these rules, and address, but not be limited to:

(a) Personnel practices and staff training;

(b) Resident selection, admission and termination;

(c) Fire drills, emergency procedures, resident safety and abuse reporting;

(d) Health and sanitation;

(e) Records;

(f) Residential service plan, services and activities;

(g) Behavior management, including prohibition of the use of seclusion or restraints;

(h) Food Service;

(i) Medication administration and storage;

(j) Resident belongings, storage and funds;

(k) Resident rights and advance directives;

(l) Complaints and grievances;

(m) Facility maintenance;

(n) Evacuation capability determination; and

(o) Fees and money management.

(4) House Rules. The RTH will develop reasonable house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies, smoking and phone use. The house rules will be consistent with resident rights as delineated in OAR 309-035-0380 and are subject to approval by the Department. House rules will be posted in an area readily accessible to residents. House rules will be reviewed and updated, as necessary. Residents will be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective.

Stat. Auth.: ORS 409.010 & 443.450

Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0300
Records

(1) General Requirements. Records will be maintained to document the legal operation of the program, personnel practices and resident services. All records will be properly obtained, accurately prepared, safely stored and readily available within the RTH. All entries in records required by these rules will be in ink, indelible pencil, or approved electronic equivalent and prepared at the time, or immediately following, the occurrence of the event being recorded; be legible; and be dated and signed by the person making the entry. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.

(2) Program Records. Records documenting the legal operation of the RTH will include, but not be limited to:

(a) Written approval for occupancy of the building by the county or city having jurisdiction, any building inspection reports, zoning verifications, fire inspection reports or other documentation pertaining to the safe and sanitary operation of the RTH;

(b) Application for license, related correspondence and site inspection reports;

(c) Program operating budget and related financial records;

(d) Payroll records, employee schedules and time sheets;

(e) Materials Safety and Data Sheets;

(f) Fire drill documentation;

(g) Fire alarm and sprinkler system maintenance and testing records;

(h) Incident reports; and

(i) Policy and procedure manual.

(3) Personnel Records. Records documenting personnel actions will include:

(a) Job descriptions for all positions; and

(b) Individual employee records including, but not limited to, written documentation of employee identifying information and qualifications, criminal record clearance, tuberculosis test results, Hepatitis B vaccinations in accordance with the Oregon Occupational Safety and Health Code, performance appraisals, and documentation of preservice orientation and other training.

(4) Resident Records. Except as indicated in OAR 309-035-0300(5), an individual resident record will be maintained for each resident and include:

(a) An easily accessible summary sheet which includes, but is not limited to the resident's name, previous address, date of admission to the facility, sex, date of birth, marital status, legal status, religious preference, Social Security number, health provider information, evacuation capability, diagnosis(es), major health concerns, medication allergies, information indicating whether advance mental health and health directives and/or burial plan have been executed, and the name of person(s) to contact in case of emergency;

(b) The names, addresses and telephone numbers of the resident's legal guardian or conservator, parent(s), next of kin, or other significant person(s); physician(s) or other medical practitioner(s); dentist; CMHP case manager or therapist; day program, school or employer; and any governmental or other agency representative(s) providing services to the resident;

(c) A mental health assessment and background information identifying the resident's residential service needs;

(d) Advance mental health and health directives, burial plans or location of these (as available);

(e) Residential service plan and copy(ies) of plan(s) from other relevant service provider(s).

(f) Documentation of the resident's progress and any other significant information including, but not limited to, progress notes, progress summaries, any use of seclusion or restraints, and correspondence concerning the resident;

(g) Health-related information and up-to-date information on medications in accordance with OAR 309-035-0440;

(h) Any authorizations obtained for the release of confidential information.

(5) Records for Crisis-respite Residents. For residents receiving crisis-respite services, an individual resident record will be maintained for each resident and include:

(a) A referral form or forms which include the resident's name; previous address; date of admission; sex; date of birth; marital status; social security number; health care provider names and phone numbers (including primary care physician, psychiatrist, prescriber (if different), and any other known health care providers); health insurance information; entitlements and/or eligibility; source and amount of income; diagnosis(es); major health concerns; current medications; medication or other allergies; name(s) of person(s) to contact in case of emergency; name, address and phone number of guardian or conservator (as applicable); and other information pertinent to the resident's crisis-respite stay;

(b) A mental health assessment and plan which include the reason for placement in crisis-respite care, the nature of crisis necessitating placement, an evaluation of risk for harm to self or others, the residential treatment plan for the crisis-respite stay, the expected duration of the crisis-respite placement, and the discharge plan;

(c) Current written orders by a qualified health care professional for all medications and a plan for obtaining any prescribed medications which are not in the resident's possession in original labeled containers;

(d) A signed resident agreement indicating informed consent for treatment; and

(e) Any authorizations obtained for the release of confidential information.

(6) Storage. All resident records will be stored in a weatherproof and secure location. Access to records will be limited to the Administrator and direct care staff unless otherwise allowed in these rules.

(7) Confidentiality. All resident records will be kept confidential. A signed release of information will be obtained for any disclosure from resident records in accordance with all applicable laws and rules.

(8) Resident Access to His/Her Record. A resident, or guardian (as applicable), will be allowed to review and obtain a copy of his/her resident record as allowed in ORS 179.505(9).

(9) Transfer of Records. Pertinent information from records of residents who are being transferred to another program will be transferred with the resident. A signed release of information will be obtained in accordance with applicable laws and rules.

(10) Maintenance of Records. The RTH will keep all records, except those transferred with a resident, for a period of three years.

(11) Administrative Changes. If an RTH changes ownership or Administrator, all resident and personnel records will remain in the home. Prior to the dissolution of any RTH, the Administrator will notify the Department in writing as to the location and storage of resident records or those records will be transferred with the residents.

(12) Resident Contributions to Record. If a resident or guardian (as applicable) disagrees with the content of the resident record, or otherwise desires to provide documentation for the record, the resident or guardian (as applicable) may provide material in writing that then will become part of the resident record.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0310
Staffing

(1) Staff Qualifications. A job description will be available for each staff position and specify qualifications and job duties.

(a) Any staff person hired to provide direct care to residents will be at least 18 years of age, be capable of implementing the RTHs emergency procedures and disaster plan, and be capable of performing other duties of the job as described in the job description.

(b) In accordance with OAR 407-007-0200 through 407-007-0380, all RTH staff who will have contact with residents will provide evidence of a criminal record clearance prior to starting employment.

(c) In accordance with OAR 333-071-0057 and 437, division 2, Subdivision Z, 4f(1)(2), all RTH staff who will have contact with residents will be tested for tuberculosis and Hepatitis B within two weeks of first employment; additional testing will take place as deemed necessary; and the employment of staff who test positive for tuberculosis will be restricted if necessary.

(d) In accordance with the Oregon Occupational Safety and Health Code, chapter 437, division 2, Subdivision Z, Hepatitis B vaccinations will be offered within ten working days of initial employment to RTH staff who will have contact with residents. Training about bloodborne pathogens and related safety practices will be completed prior to offering the vaccination.

(e) All staff will meet other qualifications when required by a contract or financing arrangement approved by the Department.

(2) Personnel Policies. Personnel policies will be made available to all staff and will describe hiring, leave, promotion and disciplinary practices.

(3) Staff Training. The administrator will provide or arrange a minimum of 16 hours pre-service orientation and eight hours in-service training annually for each employee.

(a) Pre-service training for direct care staff will include, but not be limited to, a comprehensive tour of the home; a review of emergency procedures developed in accordance with OAR 309-035-0330; a review of RTH house rules, policies and procedures; background on mental and emotional disorders; an overview of resident rights; assessment of resident risk factors; medication management procedures; food service arrangements; a summary of each resident's assessment and residential service plan; and other information relevant to the job description and scheduled shift(s).

(b) In-service training will be provided on topics relevant to improving the care and treatment of residents in the RTH and meeting the requirements in these administrative rules. In-service training topics include, but are not limited to, implementing the residential service plan, behavior management, daily living skills development, nutrition, first aid, understanding mental illness, sanitary food handling, resident rights, identifying health care needs, and psychotropic medications.

(4) General Staffing Requirements. The licensee and administrator are responsible for assuring that an adequate number of staff are available at all times to meet the treatment, health and safety needs of residents. Regardless of the minimum staffing requirements, staff will be scheduled to ensure safety and to correspond to the changing needs of residents. At a minimum, there will be at least one direct care staff person on duty at all times.

(a) In the case of a specialized RTH, staffing requirements outlined in the contractual agreement for specialized services will be implemented.

(b) Direct care staff on night duty will be awake and dressed at all times. In homes where residents are housed in two or more detached buildings, direct care staff will monitor each building at least once an hour during the night shift. An approved method for alerting staff to problems will be in place. This method must be accessible to and usable by the residents.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0320
Physical Environment Requirements

(1) Compliance with Building and Fire Codes. Each residential treatment home established on or after December 1, 1999, will meet the requirements for approved Group SR occupancies in the Building Code and the Fire Code in effect at the time of licensure. RTHs licensed as adult foster homes by the Department before the effective date of these rules will demonstrate that the home was in compliance with the Building Code and Fire Code in effect at the time of the original Department licensure. When renovation or a change in the home's use results in a new building occupancy classification, the home will meet the requirements for approved Group SR occupancies in the Building Code in effect at the time of such change.

(2) Accessibility for Persons with Disabilities. RTHs will be accessible as follows:

(a) Those homes that are licensed, constructed or renovated after January 26, 1992, and that are covered multi-family dwellings or public accommodations, will meet the physical accessibility requirements in Chapter 11 of the Oregon Structural Specialty Code. This code specifies requirements for public accommodations as defined in the Americans with Disabilities Act under Title III and for buildings qualifying as multi-family dwellings as defined in the Fair Housing Act, as amended in 1988.

(b) In order to ensure program accessibility under Title II of the Americans with Disabilities Act, the Department may require additional accessibility improvements.

(c) Any accessibility improvements made to accommodate an identified resident will be in accordance with the specific needs of the resident and will comply with the Building Code.

(3) Outdoor Areas. An accessible outdoor area is required and will be made available to all residents. For RTHs licensed on or after December 1, 1999, a portion of the accessible outdoor area will be covered and have an all weather surface, such as a patio or deck.

(4) General Storage. The home will include sufficient and safe storage areas. These will include but not be limited to:

(a) Storage for a reasonable amount of resident belongings beyond that available in resident sleeping rooms will be provided. For homes licensed on or after December 1, 1999, this storage will include 24 cubic feet per resident.

(b) All maintenance equipment stored on site, including yard maintenance tools, will be maintained in adequate storage space. Equipment and tools which pose a danger to RTH residents will be kept in locked storage.

(c) Storage areas necessary to ensure a functional, safe and sanitary environment consistent with OAR 309-035-0320, 309-035-0330, 309-035-0340, 309-035-0350, 309-035-0430, and 309-035-0440.

(5) Hallways. For RTHs initially licensed on or after December 1, 1999, all resident use areas and resident units will be accessible through temperature controlled common areas or hallways with a minimum width of 36 inches.

(6) Administrative Areas. Sufficient space will be provided for confidential storage of both resident and business records, for staff use in completing record-keeping tasks, and for a telephone. Other equip-

ment including fire alarm panels and other annunciators will be installed in an area readily accessible to staff in accordance with the Fire Code.

(7) Resident Sleeping Rooms. Resident sleeping quarters will be provided in rooms separated from other areas of the facility by an operable door with an approved latching device.

(a) For homes licensed prior to December 1, 1999, resident sleeping rooms will include a minimum of 60 square feet per resident and allow for a minimum of three feet between beds.

(b) For homes initially licensed on or after December 1, 1999, each resident sleeping room will be limited to one or two residents. At least ten per cent, but no less than one, of the resident sleeping rooms will be accessible for persons with mobility disabilities. All resident sleeping rooms will include a minimum of 70 square feet per resident exclusive of closets, vestibules and bathroom facilities and allow a minimum of three feet between beds.

(c) A clothes closet, with adequate clothes hanging rods will be accessible within each sleeping room for storage of each resident's clothing and personal belongings. For homes initially licensed on or after December 1, 1999, built-in closet space will be provided totaling a minimum of 64 cubic feet for each resident. In accessible sleeping rooms, the clothes hanging rod height will be adjustable or no more than 54 inches in height to ensure accessibility for persons in wheelchairs.

(d) Each resident sleeping room will have exterior window(s) with a combined area at least one-tenth of the floor area of the room. Sleeping room windows will be equipped with curtains or blinds for privacy and control of light. For homes initially licensed on or after December 1, 1999, an operable, opening window for emergency egress will be provided consistent with Building Code requirements.

(e) When locking devices are used on resident sleeping room doors, they will meet the requirements of the Building Code.

(8) Bathrooms.

(a) Bathing and toilet facilities will be conveniently located for resident use, provide permanently wired light fixtures that illuminate all parts of the room, provide individual privacy for residents, provide a securely affixed mirror at eye level, be adequately ventilated by a mechanical exhaust system or operable windows, and include sufficient facilities specially equipped for use by persons with a physical disability in buildings serving such persons.

(b) A minimum of one toilet, one lavatory and one bathtub or shower will be available for residents.

(9) Common Use Rooms. The home will include lounge and activity area(s), such as a living room or parlor, as required in the Building Code or totaling 25 square feet per resident, whichever is greater, for social and recreational use exclusively by residents, staff and invited guests.

(10) Laundry and Related Space. Laundry facilities will be separate from food preparation and other resident use areas. When residential laundry equipment is installed, the laundry facilities may be located to allow for both resident and staff use. The following will be included in the laundry facilities:

(a) Countertops or folding table(s) sufficient to handle laundry needs for the facility;

(b) Locked storage for chemicals and equipment;

(c) Outlets, venting and water hook-ups according to state building code requirements. Washers will have a minimum rinse temperature of 140 degrees Fahrenheit; and

(d) Sufficient, separate storage and handling space to ensure that clean laundry is not contaminated by soiled laundry.

(11) Kitchen. Kitchen facilities and equipment will be of residential type except as otherwise approved by the Department. For all kitchens, the following will be included:

(a) Dry storage space, not subject to freezing, in cabinets or a separate pantry for a minimum of one week's supply of staple foods;

(b) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space for a minimum of two days' supply of perishable foods;

(c) A dishwasher (may be approved residential type) with a minimum final rinse temperature of 140 degrees Fahrenheit;

(d) Smooth, nonabsorbent and cleanable counters for food preparation and serving;

(e) Appropriate storage for dishes and cooking utensils designed to be free from potential contamination;

(f) Stove and oven equipment for cooking and baking needs; and

(g) Storage for a mop and other cleaning tools and supplies used for food preparation, dining and adjacent areas. Such cleaning tools will be maintained separately from those used to clean other parts of the facility.

(12) Dining Area.

(a) A separate dining room or area where meals are served will be provided for the exclusive use of residents, employees, and invited guests.

(b) Dining space will be provided to seat all residents with a minimum area of 20 square feet per resident, exclusive of serving facilities and required exit pathways.

(13) Details and Finishes. All details and finishes will meet the finish requirements of applicable sections of the Building Code and the Fire Code.

(a) Surfaces. Surfaces of all walls, ceilings, windows and equipment will be readily cleanable. The walls, floors and ceilings in the kitchen, laundry and bathing areas will be nonabsorbent, and readily cleanable.

(b) Flooring. In homes initially licensed on or after December 1, 1999, flooring, thresholds and floor junctures will be designed and installed to prevent a tripping hazard. In addition, hard surface floors and base will be free from cracks and breaks, and bathing areas will have non-slip surfaces.

(c) Doors. In homes initially licensed on or after December 1, 1999, all doors to accessible resident sleeping rooms, bathrooms and common use areas will provide a minimum clear opening of 32 inches. Lever type door hardware will be provided on all doors used by residents in accessible areas. If locks are used on doors to resident sleeping rooms, they will be interactive to release with operation of the inside door handle and be master-keyed from the corridor side. Exit doors will not include locks which prevent evacuation. An exterior door alarm or other acceptable system may be provided for security purposes and to alert staff when resident(s) or others enter or exit the home.

(d) Handrails. Handrails will be provided on all stairways as specified in the Building Code.

(14) Heating and Ventilating. All areas of the home will be adequately ventilated and temperature controlled consistent with Mechanical and Building Code requirements in effect at the time of installation.

(a) Temperature Control. All habitable rooms will include heating equipment capable of maintaining a minimum temperature of 68 degrees Fahrenheit at a point three feet above the floor. During times of extreme summer heat, fans will be made available when air conditioning is not provided.

(b) Exhaust Systems. All toilet and shower rooms will be ventilated by a mechanical exhaust system or operable windows.

(c) Fireplaces, Furnaces, Wood Stoves and Boilers. Where used, design and installation will meet standards of the Mechanical Code and the Boiler and Pressure Vessel Law in effect at the time of their installation, as applicable.

(d) Water Temperature. In resident areas, hot water temperatures will be maintained within a range of 110 to 120 degrees Fahrenheit. Hot water temperatures for washing machines and dishwashers will be at least 140 degrees Fahrenheit.

(15) Electrical. All electrical systems will meet the standards of the Electrical Code in effect on the date of installation, and all electrical devices will be properly wired and in good repair.

(a) When not fully grounded, circuits in resident areas may be protected by GFCI type receptacles or circuit breakers as an acceptable alternative.

(b) All electrical circuits will be protected by circuit breakers or non-interchangeable circuit-breaker-type fuses in fuse boxes.

(c) A sufficient supply of electrical outlets will be provided to meet resident and staff needs without the use of extension cords or outlet expander devices. (See Office of State Fire Marshal and Department of Health Services policy for extension cords.)

(d) Lighting fixtures will be provided in each resident bedroom and bathroom, switchable near the entry door, and in other areas as required to meet task illumination needs.

(16) Plumbing. All plumbing will meet the Plumbing Code in effect on the date of installation, and all plumbing fixtures will be properly installed and in good repair.

(17) Telephones. The home will provide adequate access to telephones for private use by residents. In homes initially licensed on or after December 1, 1999, a phone for resident use will be provided in addition to the phone used by staff. The RTH may establish reasonable house rules governing phone use to ensure equal access by all residents. Each resident or guardian (as applicable) will be responsible for payment of long distance phone bills where the calls were initiated by the resident, unless other mutually agreed arrangements have been made.

(18) Smoking. Smoking is not allowed in sleeping areas. If there is a designated smoking area, it will be separated from other common areas. Indoor smoking areas will be equipped with a mechanical exhaust fan or central exhaust system which discharges to the outside. Furniture used in designated smoking areas will be non-flammable and without crevasses. In homes initially licensed on or after December 1, 1999, indoor smoking areas will be separated from other parts of the home by a self-closing door, contain sprinkler protection or heat detectors, and contain only non-combustible furnishings and materials.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0330
Safety

(1) Training on Safety Procedures. All staff will be trained in staff safety procedures prior to beginning their first regular shift. All residents will be trained in resident safety procedures as soon as possible during their first 72 hours of residency.

(2) Emergency Procedure and Disaster Plan. A written procedure and disaster plan will be developed to cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes and floods. The plan will be posted by the phone and immediately available to the administrator and employees. The plan will specify where staff and residents will go if the home becomes uninhabitable. The plan will be kept up to date and will include:

(a) Emergency instructions for employees;

(b) The telephone numbers of the local fire department, police department, the poison control center, the administrator, the administrator's designee, and other persons to be contacted in emergencies; and

(c) Instructions for the evacuation of residents and employees.

(3) Combustible and Hazardous Materials. Noncombustible and nonhazardous materials will be used whenever possible. When necessary to the operation of the home, flammable and combustible liquids and other hazardous materials will be safely and properly stored in clearly labeled, original containers in areas inaccessible to residents in accordance with the Fire Code. Any quantities of combustible and hazardous materials maintained will be the minimum necessary.

(4) Poisonous and Other Toxic Materials. Non-toxic cleaning supplies will be used whenever available. Poisonous and other toxic materials will be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) Evacuation Capability. Evacuation capability categories are based upon the ability of the residents and staff as a group to evacuate the home or relocate from a point of occupancy to a point of safety. Homes will be constructed and equipped according to the Building Code occupancy classification for the designated evacuation capability for occupants. Occupancy classification categories of evacuation capability include "Impractical" and "Slow" (SR-3). "Prompt" homes are regulated by the building and fire codes as R-3 occupancies. The evacuation capability designated for the facility will be documented and maintained in accordance with requirements for Group SR Occupancies in the Building Code.

(a) Only persons assessed to be capable of evacuating in accordance with the designated facility evacuation capability will be admitted to the RTH.

(b) Persons experiencing difficulty with evacuating in a timely manner will be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances, the RTH will consider increasing staff levels, changing staff assignments, offering to change the resident's room assignment, arranging for special equipment, and taking other actions that may assist the resident. Residents who still cannot evacuate the home safely in the allowable period of time will be assisted with transferring to another program with an evacuation capability designation consistent with the individual's documented evacuation capability.

(6) Evacuation Drills. Every resident will participate in an unannounced evacuation drill each month. (See Section 408.12.5 of the Fire Code.)

(a) At least once every three months, the drill will be conducted during resident sleeping hours.

(b) Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.

(c) Any resident failing to evacuate within the established time limits will be provided with special assistance and a notation made in the resident record.

(d) Written evacuation records will be retained for at least three years. They will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.

(7) Unobstructed Egress. All stairways, halls, doorways, passageways, and exits from rooms and from the home will be unobstructed.

(8) Fire Extinguishers. The program will install and maintain one or more 2A:10B:C fire extinguishers on each floor in accordance with the Fire Code.

(9) Fire and Smoke Alarms and Detectors. Approved fire and smoke alarms and detectors will be installed according to Building Code and Fire Code requirements. These alarms will be tested during each evacuation drill. The RTH will provide appropriate signal devices for persons with disabilities who do not respond to the standard auditory alarms. All of these devices will be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction.

(10) Sprinkler Systems. Sprinkler systems, if used, will be installed in compliance with the Building Code and maintained in accordance with rules adopted by the State Fire Marshal.

(11) First Aid Supplies. First aid supplies will be readily accessible to staff. All supplies will be properly labeled.

(12) Portable Heaters. Portable heaters are a recognized safety hazard and will not be used, except as approved by the State Fire Marshal or authorized representative.

(13) Safety Program. A safety program will be developed and implemented to identify and prevent the occurrence of hazards. Such hazards may include, but are not limited to, dangerous substances, sharp objects, unprotected electrical outlets, use of extension cords or other special plug-in adapters, slippery floors or stairs, exposed heating devices, broken glass, inadequate water temperatures, overstuffed furniture in smoking areas, unsafe ashtrays and ash disposal, and other potential fire hazards.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0340
Sanitation

(1) Water Supply. The water supply in the home will meet the requirements of the current rules of the Health Division governing domestic water supplies.

(a) A municipal water supply will be utilized if available.

(b) When the home is not served by an approved municipal water system, and the home qualifies as a public water system according to OAR 333-061-0020(127), Oregon Health Services rules for public water systems, then the home will comply with the OAR chapter 333 rules of the Oregon Health Services pertaining to public water systems. These include requirements that the drinking water be tested for total coliform bacteria at least quarterly, and nitrate at least annually, and reported to Health Services. For adverse test results, these rules require that repeat samples and corrective action be taken to assure compliance with water quality standards, that public notice be given whenever a violation of the water quality standards occurs, and that records of water testing be retained according to the Oregon Health Services requirements.

(2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment will be kept in good repair, clean, neat and orderly.

(3) Plumbing Fixtures. Each bathtub, shower, lavatory, and toilet will be kept clean, in good repair and regularly sanitized.

(4) Disposal of Cleaning Waste Water. No kitchen sink, lavatory, bathtub, or shower will be used for the disposal of cleaning waste water.

(5) Soiled Laundry. Soiled linens and clothing will be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.

(6) Pest Control. All necessary measures will be taken to prevent rodents and insects from entering the home. Should pests be found in the home, appropriate action will be taken to eliminate them.

(7) Grounds Maintenance. The grounds of the home will be kept orderly and reasonably free of litter, unused articles, and refuse.

(8) Garbage Storage and Removal. Garbage and refuse receptacles will be clean, durable, watertight, insect and rodent proof, and will be kept covered with tight-fitting lids. All garbage and solid waste will be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.

(9) Sewage Disposal. All sewage and liquid wastes will be disposed of in accordance with the Plumbing Code to a municipal sewage system where such facilities are available. If a municipal sewage system is not available, sewage and liquid wastes will be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality. Sewage lines, and septic tanks or other non-municipal sewage disposal systems where applicable, will be maintained in good working order.

(10) Biohazardous Waste. Biohazardous waste will be disposed of in compliance with the rules of the Department of Environmental Quality.

(11) Infection Control. Precautions will be taken to prevent the spread of infectious and/or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards.

(a) In accordance with OAR 437, division 2, subdivision Z, Section 1910.1030 of the Oregon Occupational Safety and Health Code, staff will employ universal precautions whereby all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

(b) Bathroom facilities will be equipped with an adequate supply of toilet paper, soap and towels.

(12) Infection Control for Pets and Other Household Animals. If pets or other household animals exist at the home, sanitation practices will be implemented to prevent health hazards.

(a) Such animals will be vaccinated in accordance with the recommendations of a licensed veterinarian. Proof of such vaccinations will be maintained on the premises.

(b) Animals not confined in enclosures will be under control and maintained in a manner that does not adversely impact residents or others.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0350
Resident Furnishings

(1) Bedroom Furniture. Residents will be allowed to use their own furniture within space limitations of the resident sleeping room. Otherwise, furniture will be provided or arranged for each resident, maintained in good repair and include:

(a) A bed, including a frame and a clean mattress and pillow;

(b) A private dresser or similar storage area for personal belongings which is readily accessible to the resident; and

(c) Locked storage for the resident's small, personal belongings. In homes initially licensed before December 1, 1999, this locked storage may be provided in a place other than the resident's bedroom. The resident will be provided with a key or other method to gain access to his/her locked storage space.

(2) Linens. Linens will be provided for each resident and will include:

(a) Sheets, pillowcase, other bedding appropriate to the season and individual resident's comfort;

(b) Availability of a waterproof mattress or waterproof mattress cover; and

(c) Towels and wash cloths.

(3) Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, and menstrual supplies (if needed).

(4) Supplies Provided by RTH. Sufficient supplies of soap, shampoo and toilet paper for all residents will be provided.

(5) Common Area Furniture. An adequate supply of furniture for resident use in living room, dining room and other common areas will be maintained in good condition.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0360
Admission to Home

(1) Responsibility for Admission Process. Each RTHs admission policy and procedures will specify who is responsible for each component of the admission information-gathering and decision-making process. Responsibilities will be organized and assigned to promote effective processing of referrals and admissions.

(2) Referrals. Unless limited by contractual agreement with the Department or other Department-approved party, referrals may be accepted from a variety of sources. Residents whose services will be funded by the Department must be approved for placement by the CMHP or other local entity given responsibility for this function by contract with the Department.

(3) Release of Information. In accordance with ORS 179.505 and the 45 Code of Federal Registry, Part 164, an authorization for the release of information will be obtained for any confidential information concerning a prospective resident.

(4) Nondiscrimination. Persons will be considered for admission without regard to race, color, sex or sexual orientation (except as may be limited by room arrangement), religion, creed, national origin, age (except under 18 years), familial status, marital status, source of income, or disability in addition to the mental or emotional disorder.

(5) Screening. Prior to accepting a resident for admission to the RTH, the administrator or his/her designee will determine that the resident meets admission criteria. The prospective resident will receive an explanation of the program, be given a copy of materials explaining conditions of residency, and be offered the opportunity to visit the home. Sufficient information will be obtained from the prospective resident, a relative and/or agencies providing services to determine eligibility for admission and service needs. In the case of individuals referred for emergency or crisis-respite admission, the information obtained may be less extensive than for regular admissions but must be sufficient to determine that the resident meets admission criteria and that the RTH is appropriate considering the individual's needs. Screening information will include, but not be limited to, the following:

(a) Written documentation that the prospective resident has, or is suspected of having, a mental or emotional disorder;

(b) Background information including a mental health assessment and describing previous living arrangements, service history, behavioral issues and service needs;

(c) Medical information including a brief history of any health conditions, documentation from a Licensed Medical Professional or other qualified health care professional of the individual's current physical condition, and a written record of any current or recommended medications, treatments, dietary specifications, and aids to physical functioning;

(d) Copies of documents, or other documentation, relating to guardianship, conservatorship, commitment status, advance directives, or any other legal restrictions (as applicable);

(e) A copy of the prospective resident's most recent mental health treatment plan, or in the case of an emergency or crisis-respite admission, a summary of current mental health treatment involvement; and

(f) Documentation of the prospective resident's ability to evacuate the building consistent with the RTHs designated evacuation capability and other concerns about potential safety risks.

(6) Admission Criteria. Persons considered for admission will:

(a) Be assessed to have a mental or emotional disorder, or a suspected mental or emotional disorder;

(b) Be in need of care, treatment and supervision;

(c) Be at least 18 years of age;

(d) Not require continuous nursing care, unless a reasonable plan to provide such care exists, the need for residential treatment supersedes the need for nursing care, and the Department approves the placement;

(e) Have an evacuation capability consistent with the RTHs SR Occupancy classification; and

(f) Meet additional criteria required or approved by the Department through contractual agreement or condition of licensing.

(7) Admission Decisions. A decision to admit a resident to the RTH will be made as follows:

(a) For regular admissions, the decision will be made based upon a review of screening materials at a pre-admission meeting and a determination that the resident meets the admission criteria. A pre-admission meeting will be scheduled to include the RTH administrator or designee, the potential resident and his/her legal guardian (as applicable). With the prospective resident's consent, the pre-admission meeting may also include family member(s) or other representative(s) as appropriate, representative(s) of relevant service providing agency(ies), and others with an interest in the resident's admission. The potential resident, legal guardian (as applicable) and authorized representative will be informed of the admission decision within 72 hours. If a decision is deferred or postponed, the potential resident, legal guardian (as applicable) and authorized representative will be informed of the potential resident's application status within one week of the pre-admission meeting, and weekly thereafter (as necessary). When admission is denied, the prospective resident, their legal guardian (as applicable) and authorized representative will be informed in writing of the basis for the decision and their right to appeal the decision in accordance with OAR 309-035-0390.

(b) For crisis-respite admissions, the decision will be made based upon a review of the referral materials by the RTH administrator or designee and a determination that the resident meets the admission criteria. Due to the urgent nature of crisis-respite admissions, decisions will be made on an immediate basis. The prospective resident, their legal guardian (as applicable) and authorized representative will be directly informed of the decision and their right to appeal in accordance with OAR 309-035-0390.

(8) Informed Consent for Services. The RTH will obtain informed consent for services upon admission to the RTH from each resident, or his/her guardian (as applicable), unless the resident's ability to do so is legally restricted. If such consent is not obtained, the reason will be documented and further attempts to obtain informed consent will be made as appropriate.

(9) Orientation. Upon admission, the administrator or his/her designee will provide an orientation to each new resident that includes, but is not limited to, a complete tour of the home, introductions to other residents and staff, discussion of house rules, explanation of the laundry and food service schedule and policies, review of resident rights and grievance procedures, explanation of the fee policy, discussion of the conditions under which residency would be terminated, and a general description of available services and activities. During the orientation, advance directives will be explained. If the resident does not already have any advance directive(s), she/he will be given an opportunity to complete them. Orientation will also include a description of the RTHs emergency procedures in accordance with OAR 309-035-0330(2).

(10) Record Preparation. A resident record will be established concurrent with the resident's admission. Prior to a regular admission, within five days after an emergency admission, or within 24 hours of a crisis-respite admission, the program will determine with whom communication needs to occur and will attempt to obtain the needed authorizations for release of information. The record established upon admission will include the materials reviewed in screening the resident, the summary sheet and any other available information. Every effort will be made to complete the resident record consistent with OAR 309-035-0300(4) and (5) in a timely manner. The assessment and residential service plan will be completed in accordance with OAR 309-035-0440. Records on prescribed medications and health needs will be completed as specified in OAR 309-035-0440.

Stat. Auth.: ORS 409.010 & 443.450

Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)

Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0370

Termination of Residency

(1) Responsibility for Termination Process. Each RTHs termination policy and procedures will specify who is responsible for each step of the process for terminating residency. Responsibilities will be organized and assigned to promote a fair and efficient termination process. Unless otherwise designated as a condition of licensing or in contract language approved by the Department, the Administrator will be responsible for initiating and coordinating termination proceedings. An effort will be made to prevent unnecessary terminations by making reasonable accommodations within the RTH.

(2) Crisis-respite Services. Because crisis-respite services are time-limited, the planned end of services will not be considered a termination of residency and will not be subject to requirements in OAR 309-035-0370(3), (5), (6) and (9). Upon admission to crisis-respite services, the resident or guardian (as applicable) will be informed of the planned date for discontinuation of services. This date may be extended through mutual agreement between the administrator and the resident or guardian (as applicable). RTHs providing crisis-respite services will implement policies and procedures that specify reasonable time frames and the grounds for discontinuing crisis-respite services earlier than the date planned.

(3) Voluntary Termination of Residency. A resident or guardian (as applicable) may terminate residency in the RTH upon providing at least 30 days notice. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided.

(4) Emergency Termination of Residency. If a resident's behavior poses a serious and immediate threat to the health or safety of others in or near the RTH, the administrator, after providing 24 hours written notice specifying the causes to the resident or guardian (as applicable), may immediately terminate the residency. The notice will specify the resident's right to appeal the emergency termination decision in accordance with OAR 309-035-0390.

(5) Other Terminations of Residency. When other circumstances arise providing grounds for termination of residency, the administrator will discuss these grounds with the resident, the resident's guardian (as applicable), and with the resident's permission, other persons with an interest in the resident's circumstances. If a decision is made to terminate residency, the administrator will provide at least 30 days written notice specifying the causes to the resident or guardian (as applicable). This notice will also specify the resident's right to appeal the termination decision in accordance with OAR 309-035-0390. Upon mutual agreement between the administrator and the resident or guardian (as applicable), less than 30 days notice may be provided. An effort will be made to establish a reasonable termination date in consideration of both program needs and the needs of the terminated resident to find alternative living arrangements. Criteria establishing grounds for termination include:

(a) Resident no longer needs or desires services provided at the RTH and/or expresses a desire to move to an alternative setting;

(b) Resident is assessed by a Licensed Medical Professional or other qualified health professional to require services, such as continuous nursing care or extended hospitalization, that are not available, or can not be reasonably arranged, at the RTH;

(c) Resident's behavior is continuously and significantly disruptive or poses a threat to the health or safety of self or others and these behavioral concerns cannot be adequately addressed with services available at the RTH or services that can be arranged outside of the RTH;

(d) Resident cannot safely evacuate the home in accordance with the RTHs SR Occupancy Classification after efforts described in OAR 309-035-0330(5)(b) have been taken;

(e) Nonpayment of fees in accordance with program's fee policy; and

(f) Resident continuously and knowingly violates house rules resulting in significant disturbance to others.

(6) Pre-termination Meeting. Except in the case of emergency terminations or crisis-respite services, a pre-termination meeting will be held with the resident, guardian (as applicable), and with the resident's permission, others interested in the resident's circumstances. The purpose of the meeting is to plan any arrangements necessitated by the termination decision. The meeting will be scheduled to occur at least two weeks prior to the termination date. In the event a pre-termination

meeting is not held, the reason will be documented in the resident's record.

(7) Documentation. Documentation of discussions and meetings held concerning termination of residency and copies of notices will be maintained in the resident's record.

(8) Disposition of Personal Property. At the time of termination of residency, the resident will be given a statement of account, any balance of funds held by the RTH and all property held in trust or custody by the RTH.

(a) In the event of pending charges (such as long distance phone charges or damage assessments), the program may hold back the amount of funds anticipated to cover the pending charges. Within 30 days after residency is terminated or as soon as pending charges are confirmed, the resident will be provided a final financial statement along with any funds due to the resident.

(b) In the case of resident belongings left at the RTH for longer than seven days after termination of residency, the RTH will make a reasonable attempt to contact the resident, guardian (as applicable) and/or other representative of the resident. The RTH must allow the resident, guardian (as applicable) or other representative at least 15 days to make arrangements concerning the property. If it is determined that the resident has abandoned the property, the RTH may then dispose of the property. If the property is sold, proceeds of the sale, minus the amount of any expenses incurred and any amounts owed the program by or on behalf of the resident, will be forwarded to the resident or guardian (as applicable).

(9) Absences without Notice. If a resident moves out of the RTH without providing notice, or is absent without notice for more than seven consecutive days, the administrator may terminate residency in the manner provided in ORS 105.105 to 105.168 after seven consecutive days of the resident's absence. An attempt will be made to contact the resident, guardian (as applicable) and/or other person interested in the resident's circumstances to confirm the resident's intent to discontinue residency.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0380
Resident Rights

(1) Statutory and Constitutional Rights. Each resident will be assured the same civil and human rights accorded to other citizens. These rights will be assured unless expressly limited by a court in the case of a resident who has been adjudicated incompetent and not restored to legal capacity. The rights described in paragraphs (2) and (3) of this section are in addition to, and do not limit, all other statutory and constitutional rights which are afforded to all citizens including, but not limited to, the right to vote, marry, have or not have children, own and dispose property, enter into contracts and execute documents.

(2) Rights of Service Recipients. In accordance with ORS 430.210, residents will have the right to:

(a) Choose from available services those which are appropriate, consistent with the plan developed in accordance with paragraphs (b) and (c) of this subsection, and provided in a setting and under conditions that are least restrictive to the person's liberty, that are least intrusive to the person and that provide for the greatest degree of independence;

(b) An individualized written service plan, services based upon that plan and periodic review and reassessment of service needs;

(c) Ongoing participation in planning services in a manner appropriate to the person's capabilities, including the right to participate in the development and periodic revision of the plan described in paragraph (b) of this subsection, and the right to be provided with a reasonable explanation of all service considerations;

(d) Not receive services without informed consent except in a medical emergency or as otherwise permitted by law;

(e) Not participate in experimentation without informed voluntary written consent;

(f) Receive medication only for the person's individual clinical needs;

(g) Not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure;

(h) A humane service environment that affords reasonable protection from harm and affords reasonable privacy;

(i) Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;

(j) Religious freedom;

(k) Not be required to perform labor, except personal housekeeping duties, without reasonable and lawful compensation;

(l) Visit with family members, friends, advocates and legal and medical professionals;

(m) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Department;

(n) Be informed at the start of services and periodically thereafter of the rights guaranteed by this section and the procedure for reporting abuse, and to have these rights and procedures prominently posted in a location readily accessible to the person and made available to the person's guardian and any representative designated by the person;

(o) Assert grievances with respect to infringement of the rights described in this section, including the right to have such grievances considered in a fair, timely and impartial grievance procedure;

(p) Have access to and communicate privately with any public or private rights protection program or rights advocate; and

(q) Exercise all rights described in this section without any form of reprisal or punishment.

(3) Additional Rights in RTHs. Residents will also have a right to:

(a) Adequate food, shelter and clothing, consistent with OAR 309-035-0410;

(b) A reasonable accommodation if, due to their disability, the housing and services are not sufficiently accessible;

(c) Confidential communication, including receiving and opening personal mail, private visits with family members and other guests, and access to a telephone with privacy for making and receiving telephone calls;

(d) Express sexuality in a socially appropriate and consensual manner;

(e) Access to community resources including recreation, religious services, agency services, employment and day programs, unless such access is legally restricted;

(f) Be free from seclusion and restraint;

(g) To review the RTHs policies and procedures; and

(h) Not participate in research without informed voluntary written consent.

(4) Program Requirements. The program will have and implement written policies and procedures which protect residents' rights, and encourage and assist residents to understand and exercise their rights. The program will post a listing of resident rights under these rules in a place readily accessible to all residents and visitors.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0390
Grievances and Appeals

(1) Procedures. The RTH will have a written policy and procedures concerning the resident grievance and appeal process. A copy of the grievance and appeal process will be posted in a place readily accessible to residents. A copy of the grievance and appeal process will be provided to each resident and guardian (as applicable) at the time of admission to the RTH.

(2) Grievances. A RTHs process for grievances must, at a minimum, include the following:

(a) Residents will be encouraged to informally resolve complaints through discussion with RTH staff.

(b) If the resident is not satisfied with the informal process or does not wish to use it, the resident may proceed as follows:

(A) The resident may submit a complaint in writing to the RTH administrator. The resident may receive assistance in submitting the complaint from any person whom the resident chooses. If requested by the resident, RTH staff will be available to assist the resident.

(B) The written complaint will go directly to the RTH administrator without being read by other staff, unless the resident requests or permits other staff to read the complaint.

(C) The complaint will include the reasons for the grievance and the proposed resolutions. No complaint will be disregarded because it is incomplete.

(D) Within five days of receipt of the complaint, the RTH administrator will meet with the resident to discuss the complaint. The

resident may have an advocate or other person of his/her choosing present for this discussion.

(E) Within five days of meeting with the resident, the RTH administrator will provide a written response to the resident. As part of the written response, the Administrator will provide information about the appeal process.

(F) In circumstances where the matter of the complaint is likely to cause irreparable harm to a substantial right of the resident before the grievance procedures outlined in OAR 309-035-0390(2)(b)(D) and (E) are completed, the resident may request an expedited review. The RTH administrator will review and respond in writing to the grievance within 48 hours. The written response will include information about the appeal process.

(3) Appeals. Residents, their legal guardians (as applicable) and prospective residents (as applicable) will have the right to appeal admission, termination and grievance decisions as follows:

(a) If the resident is not satisfied with the decision, the resident may file an appeal in writing within ten days of the date of the RTH administrator's response to the complaint or notification of admission denial or termination (as applicable). The appeal will be submitted to the CMHP director or designee in the county where the RTH is located.

(b) The resident may receive assistance in submitting the appeal. If requested by the resident, RTH staff will be available to assist the resident.

(c) The CMHP director or designee will provide a written response within ten days of receiving the appeal.

(d) If the resident is not satisfied with the CMHP director's decision, the resident may file a second appeal in writing within ten days of the date of the CMHP director's written response to the Administrator of the Department or designee. The decision of the Administrator of the Department will be final.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0400
Resident Assessment and Residential Service Plan

(1) Assessment. An assessment will be completed for each resident within 30 days after admission to the RTH, unless admitted to the RTH for crisis-respite services.

(a) The assessment will be based upon an interview with the resident to identify strengths, preferences and service needs; observation of the resident's capabilities within the residential setting; a review of information in the resident record; and contact with representatives of other involved agencies, family members and others, as appropriate. All contacts with others will be made with proper authorization for the release of information.

(b) Assessment findings will be summarized in writing and included in the resident's record. Assessment findings will include, but not be limited to, diagnostic and demographic data; identification of the resident's medical, physical, emotional, behavioral and social strengths, preferences and needs related to independent living and community functioning; and recommendations for residential service plan goals.

(2) Residential Service Plan. An individualized plan, identifying the goals to be accomplished through the services provided, will be prepared for each resident, unless admitted to the RTH for crisis-respite services, within 30 days after admission.

(a) The residential service plan will be based upon the findings of the resident assessment, be developed with participation of the resident and his/her guardian (as applicable), and be developed through collaboration with the resident's primary mental health treatment provider. With consent of the resident or guardian (as applicable), family members, representatives from involved agencies, and others with an interest in the resident's circumstances will be invited to participate. All contacts with others will be made with proper, prior authorization from the resident.

(b) The residential service plan will identify service needs, desired outcomes and service strategies to address, but not be limited to, the following areas: physical and medical needs, medication regimen, self-care, social-emotional adjustment, behavioral concerns, independent living capability and community navigation.

(c) The residential service plan will be signed by the resident, the administrator or other designated RTH staff person, and others, as appropriate, to indicate mutual agreement with the course of services outlined in the plan.

(3) Crisis-respite Requirements. For residents admitted to RTHs for 30 days or less, an assessment and residential service plan must be developed within 48 hours of admission which identifies service needs, desired outcomes and the service strategies to be implemented to resolve the crisis or address other needs of the individual that resulted in the short term service arrangement.

(4) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes identified in the residential service plan. A progress note will be entered in the resident's record at least once each month for regular residents and at least daily for crisis-respite residents.

(5) Re-assessments and Revisions to the Residential Service Plan. The assessment and residential service plan will be reviewed and updated at least annually. On an ongoing basis, the residential service plan will be updated, as necessary, based upon changing circumstances or upon the resident's request for reconsideration.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0410
Resident Services and Activities

(1) General Requirements. The services and activities available at the RTH will include care and treatment consistent with ORS 443.400 and those services individually specified for the resident in the residential service plan developed as outlined in OAR 309-035-0400. Residents will be encouraged to care for their own needs to the extent possible. All services and activities will be provided in a manner that respects residents' rights, promotes recovery and affords personal dignity.

(2) Services and Activities to Be Available. Services and activities to be available will include but not be limited to:

(a) Provision of adequate shelter consistent with OAR 309-035-0320 through 309-035-0350;

(b) At least three meals per day, seven days per week, provided in accordance with OAR 309-035-0430;

(c) Assistance and support, as necessary, to enable residents to meet personal hygiene and clothing needs;

(d) Laundry services, which may include access to washer(s) and dryer(s) so residents can do their own personal laundry;

(e) Housekeeping essential to the health and comfort of residents;

(f) Activities and opportunities for socialization and recreation both within the facility and in the larger community;

(g) Health-related services provided in accordance with OAR 309-035-0440;

(h) Assistance with community navigation and transportation arrangements;

(i) Assistance with money management, where requested by a resident, to include accurate documentation of all funds deposited and withdrawn when funds are held in trust for the resident;

(j) Assistance with acquiring skills to live as independently as possible;

(k) Assistance with accessing other additional services, as needed; and

(l) Any additional services required under contract with the Department.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0420
Prohibition of Seclusion and Restraints

General Prohibition. The use of seclusion or restraints is prohibited in Residential Treatment Homes. Only Secure Residential Treatment Facilities approved by the Department in accordance with OAR 309-035-0100 through 309-035-0190 will be allowed to use seclusion and restraints.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0430
Food Services

(1) Well-balanced Diet. Meals will be planned and served in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid.

(2) Modified or Special Diets. An order from a Licensed Medical Professional will be obtained for each resident who, for health reasons, is on a modified or special diet. Such diets will be planned in consultation with the resident.

(3) Menus. Menus will be prepared at least one week in advance and will provide a sufficient variety of foods served in adequate amounts for each resident at each meal and adjusted for seasonal changes. Records of menus, as served, will be filed and maintained in the RTH for at least 30 days. Resident preferences and requests will be considered in menu planning. Religious and vegetarian preferences will be reasonably accommodated.

(4) Supply of Food. Adequate supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days will be maintained on the premises.

(5) Sanitation. Food will be stored, prepared and served in accordance with the Oregon Health Services Food Sanitation Rules.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0440
Health Services

(1) General. The administrator will be responsible for assuring that all residents are offered medical attention when needed. Arrangements for health services will be made with the informed consent of the resident and/or guardian (as applicable). The RTH will arrange for physicians or other qualified health care professionals to be available in the event the resident's regular physician or other health care professional is unavailable. A hospital emergency room will be identified and may be used in case of emergency.

(2) Initial Health Screening. Each resident admitted to the RTH will be screened by a qualified health care professional to identify health problems and to screen for communicable disease. Documentation of the initial health screening will be placed in the resident record.

(a) The health screening will include a brief history of health conditions, current physical condition and a written record of current or recommended medications, treatments, dietary specifications, and aids to physical functioning.

(b) For regular admissions, the health screening will be obtained prior to the resident's admission and include the results of testing for tuberculosis and Hepatitis B.

(c) For emergency admissions, including crisis-respite admissions, the health screening will be obtained as follows:

(A) For individuals experiencing psychiatric or medical distress, a health screening will be completed by a qualified health care professional prior to the resident's admission or within 24 hours of the emergency placement. The health screening will confirm that the individual does not have health conditions requiring continuous nursing care, a hospital level of care, or immediate medical assistance. For each crisis-respite resident who continues in the RTH for more than seven consecutive days, a complete health examination will be arranged if any symptoms of a health concern exist.

(B) For other individuals who are admitted on an urgent basis due to a lack of alternative supportive housing, the health screening will be obtained within 72 hours after the resident's admission.

(C) The health screening criteria may be waived for individuals admitted for crisis-respite services who are under the active care of an LMP or other qualified health care professional if it is the opinion of the attending health care professional that the crisis-respite placement presents no health risk to the individual or other residents in the RTH. Such a waiver must be provided in writing and be signed and dated by the attending health care professional within 24 hours of the resident's admission.

(3) Regular Health Examinations. Except for crisis-respite residents, the program will ensure that each resident has a primary physician or other qualified health care professional who is responsible for monitoring his/her health care. Regular health examinations will be done in accordance with the recommendations of this primary health care professional, but not less than once every three years. New residents will have a health examination completed within one year prior to admission or within three months after admission. Documentation of findings from each examination will be placed in the resident's record.

(4) Written Orders for Special Needs. A written order, signed by a physician or other qualified health care professional, is required for any medical treatment, special diet for health reasons, aid to physical functioning or limitation of activity.

(5) Medications. A written order signed by a physician or other qualified health care professional is required for all medications administered or supervised by RTH staff. This written order is required before any medication is provided to a resident. All medication maintained in the RTH will be provided to residents in accordance with the applicable written orders.

(a) Medications will be self-administered by the resident if the resident demonstrates the ability to self-administer medications in a safe and reliable manner. In the case of self-administration, both the written orders of the prescriber and the residential service plan will document that medications will be self-administered. The self-administration of medications may be supervised by RTH staff who may prompt the resident to administer the medication and observe the fact of administration and dosage taken. When supervision occurs, staff will enter information in the resident's record consistent with section OAR 309-035-0440(5)(h) below.

(b) Staff who assist with administration of medication will be trained by a Licensed Medical Professional or other qualified health care professional on the use and effects of commonly used medications.

(c) Medications prescribed for one resident will not be administered to, or self-administered by, another resident. Medication will not be used for the convenience of staff or as a substitute for programming. Medications will not be withheld or used as reinforcement or punishment.

(d) Stock supplies of prescription medications will not be maintained. The RTH may maintain a stock supply of non-prescription medications.

(e) The RTH will provide and implement a policy and procedure which assures that all orders for prescription drugs are reviewed by a qualified health care professional, as specified by a physician or other qualified health care professional, but not less often than every six months. Where this review identifies a contra-indication or other concern, the resident's primary physician, LMP or other primary health care professional will be immediately notified.

(f) Each resident receiving psychotropic medications will be evaluated at least every three months by the LMP prescribing the medication. The RTH will obtain from the LMP the results of this evaluation and any changes in the type and dosage of medication, the condition for which it is prescribed, when and how the medication is to be administered, common side effects (including any signs of tardive dyskinesia, contra-indications or possible allergic reactions), and what to do in case of a missed dose or other dosing error.

(g) All unused, discontinued, outdated or recalled medications, and any medication containers with worn, illegible or missing labels will be disposed. The method of disposal will be safe, consistent with any applicable federal statutes, and designed to prevent diversion of these substances to persons for whom they were not prescribed. A written record of all disposals will be maintained and specify the date of disposal, a description of the medication, its dosage potency, amount disposed, the name of the individual for whom the medication was prescribed, the reason for disposal, the method of disposal, and the signature of the staff person disposing the medication. For any medication classified as a controlled substance in schedules 1 through 5 of the Federal Controlled Substance Act, the disposal must be witnessed by a second staff person who documents their observation by signing the disposal record.

(h) All medications will be properly and securely stored in a locked space for medications only in accordance with the instructions provided by the prescriber or pharmacy. Medications for all residents will be labeled. Medications requiring refrigeration must be stored in an enclosed locked container within the refrigerator. The RTH will assure that residents have access to a locked, secure storage space for their self-administered medications. The RTH will note in its written policy and procedures which persons have access to this locked storage and under what conditions.

(i) For all residents taking prescribed medication, staff will record in the medical record each type, date, time and dose of medication provided. All side effects, adverse reactions and medications errors will be documented in the resident's record. All serious adverse reactions or errors will be reported immediately to the prescribing health care professional. All other errors, adverse reactions or refusals of medication will be reported to the prescribing professional within 48 hours.

(j) P.r.n. medications and treatments will only be administered in accordance with the parameters specified by the prescribing health care professional, or in cases where a nurse assigns or delegates p.r.n. medication or treatment administration, in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

(6) Delegation of Nursing Tasks. Where a nurse is involved in the care of an RTH resident, nursing tasks may be assigned or delegated by a Registered Nurse to direct care staff in accordance with administrative rules of the Board of Nursing, chapter 851, division 47.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0450
Civil Penalties

(1) Applicability of Long Term Care Statute. For purposes of imposing civil penalties, RTHs licensed under ORS 443.400 to 443.455 and subsection (2) of ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 to 441.745.

(2) Sections of Rule Subject to Civil Penalties. Violations of any requirement within any part of the following sections of the rule may result in a civil penalty:

(a) 309-035-0270 Licensing;
(b) 309-035-0280 Contracts and Rates;
(c) 309-035-0290 Administrative Management;
(d) 309-035-0300 Records;
(e) 309-035-0310 Staffing;
(f) 309-035-0320 Facility Requirements;
(g) 309-035-0330 Safety;
(h) 309-035-0340 Sanitation;
(i) 309-035-0350 Resident Furnishings;
(j) 309-035-0360 Admission to Facility;
(k) 309-035-0370 Termination of Residency;
(l) 309-035-0380 Resident Rights;
(m) 309-035-0390 Grievances and Appeals;
(n) 309-035-0400 Resident Assessment and Residential Service Plan;
(o) 309-035-0410 Resident Services and Activities;
(p) 309-035-0420 Use of Seclusion or Restraints;
(q) 309-035-0430 Food Services; and
(r) 309-035-0440 Health Services.

(3) Assessment of Civil Penalties. Civil penalties will be assessed in accordance with the following guidelines:

(a) Civil penalties, not to exceed $250 per violation to a maximum of $1,000, may be assessed for general violations of these rules. Such penalties will be assessed after the procedures outlined in OAR 309-035-0270(8) have been implemented;

(b) A mandatory penalty up to $500 will be assessed for falsifying resident or facility records or causing another to do so;

(c) A mandatory penalty of $250 per occurrence will be imposed for failure to have direct care staff on duty 24 hours per day;

(d) Civil penalties up to $1,000 per occurrence may be assessed for substantiated abuse;

(e) In addition to any other liability or penalty provided by the law, the Department may impose a penalty for any of the following:

(A) Operating the RTH without a license;

(B) Operating with more residents than the licensed capacity; and

(C) Retaliating or discriminating against a resident, family member, employee, or other person for making a complaint against the program.

(f) In imposing a civil penalty, the following factors will be taken into consideration:

(A) The past history of the person incurring the penalty in taking all feasible steps or procedures to correct the violation;

(B) Any prior violations of statutes, rules or orders pertaining to the RTH;

(C) The economic and financial conditions of the person incurring the penalty;

(D) The immediacy and extent to which the violation threatens or threatened the health, safety or welfare of one or more residents; and

(E) The degree of harm caused to residents.

(4) Notification. Any civil penalty imposed under this section will become due and payable ten days after notice is received, unless a request for a hearing is filed. The notice will be delivered in person, or sent by registered or certified mail and will include a reference to the particular section of the statute or rule involved, a brief summary of the violation, the amount of the penalty or penalties imposed, and a statement of the right to request a hearing.

(5) Request for Hearing. The person to whom the notice is addressed will have ten days from the date of receipt of the notice to request a hearing. This request must be in writing and submitted to the Administrator of the Department. If the written request for a hearing is not received on time, the Department will issue a final order by default.

(6) Hearings. All hearings will be conducted pursuant to the applicable provisions of ORS 183.310 to 183.550, Administrative Procedure and Rules for Civil Penalties.

(7) Judgment. Unless the penalty is paid within ten days after the order becomes final, the order constitutes a judgment and may be recorded by the County Clerk which becomes a lien upon the title to any interest in real property owned by the person. The Department may also take action to revoke the license upon failure to comply with a final order.

(8) Judicial Review. Civil penalties are subject to judicial review under ORS 183.480, except that the court may, at its discretion, reduce the amount of the penalty.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

309-035-0460
Criminal Penalties

(1) Specification of Criminal Penalty. Violation of any provision of ORS 443.400 through ORS 443.455 is a Class B misdemeanor.

(2) Grounds for Law Suit. In addition, the Department may commence an action to enjoin operation of a RTH:

(a) When a RTH is operated without a valid license; or

(b) When a RTH continues to operate after notice of revocation has been given and a reasonable time has been allowed for placement of residents in other programs.

Stat. Auth.: ORS 409.010 & 443.450
Stats. Implemented: ORS 443.400 - 443.455 & 443.991(2)
Hist.: MHD 7-1999, f. 11-15-99, cert. ef. 12-1-99; MHD 5-2005, f. & cert. ef. 4-1-05

Regulation of County Capacity of Residential Care Facilities

309-035-0500
Residential Facilities

(1) Effective September 1, 1988, and except as otherwise provided in this rule, the capacity of all **Residential Facilities** or home for adults, including foster care homes, group care facilities or residential treatment, training or care facilities, located throughout the state shall not exceed a target based on the number of beds available in 1979, updated at the rate of ten percent per year, as distributed on the basis of the Oregon population by county. The distribution shall be determined by the Department of Human Services annually.

(2) Where a county possesses less than one percentile of the State population, then the county with the lowest percentile within a Department of Human Services' region shall be grouped until such time as the group reaches one percentile of the State population in determining the distribution target.

(3) Nothing in this rule is intended to prevent placement of a person who was not initially a resident of the county in a domiciliary care facility in the county. The targeted number of beds shall not require reduction in any domiciliary care facility capacity existing on October 4, 1977. No domiciliary care facility will be required to suspend operations, nor will the Department of Human Services support be denied such facilities on the basis of the facility being located in a county or county grouping which exceeds the distribution target.

(4) Adult Foster Care Homes as described in section (1) of this rule does not include Adult Foster Care Homes in which the clients of these homes are directly related by blood or marriage to the operator of the homes.

(5) In cases for which the distribution target for residential facilities, except Adult Foster Care Homes, allows for additional capacity in a county or county grouping and such additional capacity is less than ten beds, then one additional facility of the same type of ten-bed capacity may be authorized.

(6) This rule applies only to those residential care facilities as described in sections (1) and (4) of this rule which are established by, contracted for, or operated by the Department of Human Services or any of its divisions.

(7) Nothing in this rule will exempt any residential facility from the regulations of funding limitations of the Department of Human Services or any of its divisions.

(8) Subject to the appropriate licensing requirements, the governing body of a county may authorize a residential facility located in the county to exceed the capacity limit upon:

(a) Request of an individual or organization operating or proposing to operate a residential facility;

(b) Consultation with an advisory committee appointed by the governing body and consisting of persons who are particularly interested in the type of residential facility contemplated; and

(c) Finding of good cause following notice and public hearing.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050

Stats. Implemented: 409.050

Hist.: HR 1-1978, f. & ef. 2-16-78; HR 17-1979, f. & ef. 11-19-79; HR 5-1988, f. & cert. ef. 9-1-88; Renumbered from 410-004-0001, MHS 7-2007, f. & cert. ef. 5-25-07

Residential Care, Treatment, and Training Facilities Providing Services to Residential Care Clients

309-035-0550
Purpose

(1) OAR 309-035-0060 through 309-035-0090 establish a long-range goal wherein ultimately residential care and adult foster home clients of the Department of Human Services, whose primary service needs are associated with mental retardation or other developmental disabilities, or mental or emotional disturbance, or alcohol or drug abuse or dependence, will reside in Adult Residential Care Facilities and Adult Foster Homes under the jurisdiction of the Mental Health and Developmental Disability Services Division serving only such category of residents. Those clients not having such primary service needs will reside in facilities under the jurisdiction of the Senior and Disabled Services Division, serving only such category of residents.

(2) The goal is realized by assigning certain facilities to the jurisdiction of the Mental Health and Developmental Disability Services Division with interim procedures for case management of mixed clients and by prescribing those facilities to which new placements will be made.

Stat. Auth.: ORS 409.050

Stats. Implemented: 409.050

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85; Renumbered from 410-005-0080, MHS 7-2007, f. & cert. ef. 5-25-07

309-035-0560
Definitions

As used in OAR 309-035-0060 through 309-035-0090:

(1) "Mental Retardation" means:

(a) A person with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **Manual on Terminology and Classification in Mental Retardation** of the American Association on Mental Deficiency, **1977 Revision**, by this reference made a part hereof. Mental retardation is synonymous with mental deficiency;

(b) For community case management and program purposes, mental retardation includes those persons of borderline intelligence who have a history of residency in a state training center.

(2) "Developmental Disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions which require training similar to that required by mentally retarded individuals, and the disability:

(a) Originates before the individual attains age 22 except that in the case of mental retardation the condition must be manifested before the age of 18;

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the individual's ability to function in society.

(3) "Mental or Emotional Disturbance" means a disorder of emotional reactions, thought processes, behavior, or relationships (excluding mental retardation, alcoholism and drug abuse or dependency) which results in substantial subjective distress, impaired perceptions of reality, or impaired ability to control or appreciate the consequences of one's behavior, and which constitutes a substantial impairment of personal, interpersonal, work, educational or civic functioning. If a medical diagnosis is made, classification shall be consistent with the current **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association 1980, by this reference made a part hereof.

(4) "Alcohol or Drug Abuse" or "Dependence" means a person who has lost the ability to control the use of alcohol or controlled substances or other substances with abuse potential, or who uses alcohol or such substances to the extent that the person's health or that of others is substantially impaired or endangered or the person's social or economic functions are substantially disrupted. An alcohol or drug dependent person may be physically dependent, a condition in which the body requires a continuing supply of alcohol, a drug, or controlled substance to avoid characteristic withdrawal symptoms, or psychologically dependent, a condition characterized by an overwhelming mental desire for continued use of alcohol, a drug, or a controlled substance.

(5) "Residents" mean persons who are clients of the Department of Human Services who reside in Adult Residential Care Facilities and Adult Foster Homes.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050

Stats. Implemented: 409.050

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85; Renumbered from 410-005-0085, MHS 7-2007, f. & cert. ef. 5-25-07

309-035-0570
Jurisdiction Over Homes and Centers

(1) The Mental Health and Developmental Disability Services Division shall have jurisdiction over and shall license all Adult Residential Care Homes and Centers and certify Adult Foster Homes having residents 60 percent or more of which have primary service needs associated with mental retardation or other developmental disabilities, or mental or emotional disturbance or alcohol or drug abuse dependence.

(2) Adult Residential Care Homes and Centers and Adult Foster Homes not within the criteria in section (1) of this rule shall be under the jurisdiction of and be licensed or certified by the Senior and Disabled Services Division.

Stat. Auth.: ORS 409.050

Stats. Implemented: 409.050

Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85; Renumbered from 410-005-0090, MHS 7-2007, f. & cert. ef. 5-25-07

309-035-0580
Case Management

(1) Those residents in homes and centers under the jurisdiction of Mental Health and Developmental Disability Services Division, whose primary service needs are not associated with mental retardation or other developmental disabilities, or mental or emotional disturbances or alcohol or drug abuse or dependence shall be Senior and Disabled Services Division clients and shall receive case management from such Division. All other residents in such facilities shall be Mental Health and Developmental Disability Services Division clients and shall receive case management from such Division.

(2) Those residents in Adult Residential Care Homes and Centers and Adult Foster Homes under the jurisdiction of the Senior and Disabled Services Division whose primary service needs are associated with mental retardation or other developmental disabilities, or mental or emotional disturbance or alcohol or drug abuse or dependence, shall be Mental Health and Developmental Disability Services Division

clients and shall receive case management from such Division. All other residents in such facilities shall be Senior and Disabled Services Division clients and receive case management from such Division.

Stat. Auth.: ORS 409.050
Stats. Implemented: 409.050
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85; Renumbered from 410-005-0095, MHS 7-2007, f. & cert. ef. 5-25-07

309-035-0590
Placement

(1) Residential Care and Adult Foster Home clients shall be newly placed on the basis of primary service needs -- Those having such needs as those described in OAR 309-035-0070(1) will be placed in the facilities described in that paragraph and those not having such needs shall be placed in those facilities described in OAR 309-035-0070(2).

(2) Exceptions may be made only when a client cannot be placed because of the unavailability of an appropriate facility and the facility in which the client is placed is capable of serving the needs of the client. Exceptions will be granted by the Division responsible for the receiving facility.

Stat. Auth.: ORS 409.050
Stats. Implemented: 409.050
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85; Renumbered from 410-005-0100, MHS 7-2007, f. & cert. ef. 5-25-07

309-035-0600
Effective Date

OAR 309-035-0550 through 309-035-0590 are prospective as well as retroactive to July 1, 1982. Such prospective and retroactive effect is each severable of the other.

Stat. Auth.: ORS 409.050
Stats. Implemented: 409.050
Hist.: HR 2-1984(Temp), f. & ef. 7-16-84; HR 3-1985, f. 2-28-85, ef. 3-1-85; Renumbered from 410-005-0105, MHS 7-2007, f. & cert. ef. 5-25-07

DIVISION 36

COMMUNITY MENTAL HEALTH HOUSING FUND

309-036-0100
Statement of Purpose

Statement of Purpose. These rules prescribe standards for the administration of the Community Mental Health Housing Fund. The Community Mental Health Housing Fund, supported in part by the Community Housing Trust Account, shall be administered by the Department of Human Services, through its Office of Mental Health and Addiction Services.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 426.502 - 426.508
Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

309-036-0105
Definitions

As used in these rules:

(1) "Community housing" means real property, improvements and related equipment that are used or could be used to house persons with a serious mental illness in community-based settings consistent with ORS 426.502(2). It does not include hospitals, nursing homes, correctional facilities and other institutional housing except as provided in subsection (5) of this rule.

(2) "Construct" means to build, install, assemble, expand, alter, convert, repair, replace or relocate. It can also mean to install equipment and necessary infrastructure to prepare a site.

(3) "Department" means the Department of Human Services.

(4) "Equipment" means furnishings, fixtures or appliances that are used or could be used to provide community housing.

(5) "Institutional housing" means a state psychiatric hospital in Oregon, such as Eastern Oregon Psychiatric Center or Oregon State Hospital.

(6) "Person with serious mental illness" means an individual who is:

(a) Diagnosed by a qualified mental health professional as suffering from a chronic mental disorder as defined by ORS 426.495(2)(b) which includes, but is not limited to, conditions such as schizophrenia, serious affective and paranoid disorders, and other disorders which manifest symptoms that are not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism; which continue for more than one year, or on the basis of a specific diagnosis, are likely to continue for more than one year; and

(b) Is impaired to an extent which substantially limits the person's consistent functioning in one or more of the following areas:

(A) Home environment: independently attending to shelter needs, personal hygiene, nutritional needs and home maintenance;

(B) Community negotiation: independently and appropriately utilizing community resources for shopping, recreation and other needs;

(C) Social relations: establishing and maintaining supportive relationships;

(D) Vocational: maintaining employment sufficient to meet personal living expenses or engaging in other age appropriate activities.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 426.502 - 426.508
Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

309-036-0110
Community Mental Health Housing Fund, Community Mental Health Housing Trust Account, Income and Expenditures

(1) Community Mental Health Housing Fund. The Community Mental Health Housing Fund shall be maintained in the State Treasury. All earnings on investments of moneys in the Community Mental Health Housing Fund, including earnings in the Community Housing Trust Account, shall accrue to the Fund. All moneys in the Fund shall be continuously appropriated to the Department of Human Services to carry out the provisions of ORS 426.504 through its Office of Mental Health and Addiction Services for the purpose of providing housing for persons with serious mental illness.

(a) Income to the Community Mental Health Housing Fund shall consist of:

(A) The proceeds, less costs to the state, received from the sale of the F.H. Dammasch State Hospital property under ORS 426.508;

(B) Moneys appropriated to the Fund by the Legislative Assembly;

(C) Proceeds from the sale, transfer or lease of any surplus real property owned, operated or controlled by the Department and used as community housing;

(D) Money reallocated from other areas of the Department's budget;

(E) Interest and earnings credited to the fund; and

(F) Gifts of money or other property from any source, to be used for the purposes of developing housing for persons with serious mental illness. Except as provided by ORS 426.406(3)(a), income to the fund may be restricted to deposit in the Community Housing Trust Account or may be available for expenditure.

(b) Gifts and other deposits may be designated by the contributor to be used for community housing purposes or institutional housing purposes. Such deposits may also be restricted to the Community Housing Trust Account or may be non-restricted and available for expenditure from the Fund. Any gifts restricted by a contributor shall not be available for re-allocation except as may be specified by the contributor.

(2) Community Housing Trust Account. The Community Housing Trust Account exists within the Community Mental Health Housing Fund and shall consist of:

(a) At least 95% of the proceeds received from the sale of the F.H. Dammasch State Hospital property under ORS 426.508; and

(b) Any other funds deposited into the account for the restricted purpose of staying in the Fund for perpetuity.

(3) Amounts Available for Expenditure. Amounts available from the Fund for expenditure shall consist of:

(a) Up to five percent of the sale proceeds received by the Department of Human Services for credit to the account from the Oregon Department of Administrative Services from the sale of the F.H. Dammasch State Hospital property under ORS 426.508; and

(b) All other deposited, unrestricted funds or account earnings unless a specific deposit is designated by its maker to be placed in the restricted portion of the Community Housing Trust Account.

(4) Expenditure of Community Housing Trust Account Interest Earnings. Interest earned on moneys in the Community Housing Trust Account may be expended in the following manner: Seventy percent of interest earned on deposits in the Community Housing Trust Account shall be expended for community housing purposes in accor-

dance with 309-036-0115. Thirty percent of interest earned on deposits in the Community Housing Trust Account shall be expended for institutional housing purposes in accordance with 309-036-0120.

(5) Limitations on Expenditure. Interest earned on deposits in the account shall not be used to support operating expenses of the Department.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 426.502 - 426.508
Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

309-036-0115
Community Housing

(1) As used in this rule, the term "community housing" does not include institutional housing.

(2) Eligible Uses for Community Housing. The community housing to be assisted with funds from the Community Mental Health Housing Fund shall include a variety of types of housing integrated into residential neighborhoods of local communities throughout Oregon. The Office of Mental Health and Addiction Services may establish priorities for the types of housing to be assisted based on an analysis of housing needs of persons with serious mental illness. The community housing types to be considered for funding include, but are not limited to, apartments, residential facilities and other residences for persons with serious mental illness. Housing for persons with serious mental illness may include improvements and related equipment to enable a provider to offer services on site. Where services are not offered on site, the community housing provider must demonstrate that access to services is available elsewhere in the community.

(a) New and Existing Community Housing. Funds from the Community Mental Health Housing Fund may be used to develop new community housing or to preserve or renovate existing community housing for persons with serious mental illness. To this end, funding may be used toward acquisition, maintenance, repair, furnishings and equipment.

(b) Occupancy of Community Housing. The community housing to be assisted with funds from the Community Mental Health Housing Fund must be made available for occupancy by persons with serious mental illness. Consistent with the designated housing model, additional individuals, such as resident managers, care providers, family members and roommates, may also reside in the housing to the extent allowed under ORS 426.502(2).

(c) Exclusions. Funds from the Community Mental Health Housing Fund cannot be used to support ongoing operation of the community housing.

(3) Allocation of Funds for Community Housing Purposes. The Department's Assistant Director for Health Services shall annually identify the amount of funds available in the Community Mental Health Housing Fund for community housing purposes.

(a) Allocation Plan. The Department's Assistant Director for Health Services or designated representative shall establish, with advice and input from the Community Mental Health Housing Fund Advisory Committee, a plan for allocating funds. This allocation plan shall designate amounts available for new development and renovation awards, geographic distribution goals and any desired housing types or resident population priorities.

(b) Distribution Plan. As funds become available, it shall be the intent of the Department to distribute funds in a fair and equitable manner with respect to geographic and service population considerations. To this end, regional distribution goals will be established by the Department with input from the Mental Health Housing Fund Advisory Committee. These goals will be established based upon the general population distribution in Oregon, OMHAS data on the number of persons with serious mental illness served in each region of the state and other factors relating to housing needs. The distribution plan goals will be published in the application materials. If after considering all applications for a region, the resulting awards do not award all funds in accordance with these goals, then remaining funds may be re-allocated to other regions.

(4) Application Process and Award of Funds. OMHAS shall implement an application and award process consistent with the following guidelines.

(a) Notification: OMHAS shall announce the availability of funding from the Community Mental Health Housing Fund and provide instructions for applying for such funding. The announcement of funding shall include a description of the fund, the allocation plan, eligible community housing, application rating criteria, and application materials.

(b) Application. An application for funding shall contain all information required by the department, including, but not limited to:

(A) A description of the proposed community housing project (including, but not limited to, type of unit(s), number of residents who will be persons with serious mental illness, proposed rents, site location, the services to be available to residents and project amenities);

(B) Documentation of the applicant's experience with developing and operating housing;

(C) A statement identifying the length of time the unit(s) will be dedicated for use by persons with serious mental illness;

(D) An estimate of the operating revenues and expenses;

(E) The development plan, including a development budget with sources of funding identified; and

(F) Documentation describing how the proposed community housing is consistent with allocation plan priorities. Applicants will have a minimum of 60 days to complete and return applications.

(c) Determination. Completed applications shall be submitted to the Administrator of the Office of Mental Health and Addiction Services. Applications shall be reviewed and rated by a review panel established by the OMHAS Administrator that will include at least three members of the Community Mental Health Housing Fund Advisory Committee. The review panel shall make recommendations for funding decisions to the OMHAS Administrator who will make final funding decisions. Applicants will receive written notice of funding decisions.

(d) Right to Appeal. Applicants who do not agree with funding decisions are encouraged to discuss their complaint with Office of Mental Health and Addiction Services staff. If the issue is not resolved, applicants may submit a request for formal review of the decision to the Department's Assistant Director for Health Services. The Assistant Director shall appoint a review committee whose members shall review the application materials and request for appeal and make a recommendation in 30 days. The Assistant Director shall make a decision based upon this recommendation within 15 days. The decision of the Assistant Director shall be final.

(5) Disbursement of Funds. OMHAS will development procedures for the disbursement of funds consistent with prudent accounting practices and Department financial procedures.

(6) Security of Investment. All funds disbursed in amounts greater than $5,000 for the purpose of community housing shall be secured by a trust deed or other instrument to secure and insure continuing use of the property, improvements and related equipment in accordance with the purposes of the award.

(7) Non-discrimination. Recipients of funding for community housing shall ensure that all eligible persons with serious mental illness shall be considered for residency without regard to race, color, sex or sexual orientation (except as may be limited by room arrangement), religion, creed, national origin, age (except under 18), familial status, marital status, source of income, or disability in addition to the mental or emotional disorder.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 426.502 - 426.508
Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

309-036-0120
Institutional Housing

(1) Eligible Uses for Institutional housing. The institutional housing to be assisted with 30% of interest earnings from the Community Housing Trust Account and any other funds restricted to institutional housing purposes shall mean state psychiatric hospital facilities including buildings, grounds, leased facilities, infrastructure and ancillary facilities. The institutional housing to be assisted must be for occupancy by persons with serious mental illness.

(2) Allocation of Funds for Institutional Housing Purposes. The Department's Assistant Director for Health Services or designee will annually identify the amount of funds available in the Community Mental Health Housing Fund for institutional housing purposes.

(a) Allocation Plan. The superintendents of the state psychiatric hospital facilities shall submit prioritized requests for funding of institutional housing improvements to the Assistant Director for Health Services or designee. The Assistant Director for Health Services or designee shall create an allocation plan based on a consolidated prioritized list of requests.

(b) Distribution of Funds for Institutional Housing Purposes. As funds become available, they will be distributed to state psychiatric hospital facilities for improvements in accordance with the allocation plan.

(3) Oversight. The Community Mental Health Housing Fund Advisory Committee shall review the allocation plan and distribution of funds for institutional housing purposes.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 426.502 - 426.508
Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

309-036-0125
Community Mental Health Housing Fund Advisory Committee

(1) Membership and Term. The Community Mental Health Housing Fund Advisory Committee (CMHHFAC) shall be comprised of not less than seven (7) members who shall be appointed by the Department's Assistant Director for Health Services or designee. Each member shall be appointed for a term of four years, and may be re-appointed for one additional four-year term. For initial appointments, approximately half of the members shall be appointed for initial two-year terms.

(2) Committee Composition. CMHHFAC members shall consist of at least one OMHAS employee who shall be responsible for convening the committee. OMHAS shall provide clerical support to the committee. Additional members shall include at least one state psychiatric hospital representative, one consumer advocate, one family advocate, one representative from the Housing and Community Services Department, one community mental health service provider, and one nonprofit housing provider.

(3) Meeting Schedule. The CMMHFAC shall meet not less than two times per year.

(4) Responsibilities. The CMHHFAC shall be responsible for:

(a) Recommending an allocation plan for funding awards from the Community Mental Health Housing Fund;

(b) Recommending maximum award amounts;

(c) Reviewing and evaluating the award decisions for community housing awards and making recommendations regarding the award process;

(d) Making policy recommendations for the operation of the fund; and

(e) Such other advisory actions as might be assigned by the Department's Assistant Director for Health Services.

Stat. Auth.: ORS 430.640
Stats. Implemented: ORS 426.502 - 426.508
Hist.: MHD 7-2003, f. 8-15-03 cert. ef. 9-1-03

DIVISION 39

STANDARDS FOR THE APPROVAL OF PROVIDERS OFNON-INPATIENT MENTAL HEALTH TREATMENT SERVICES

309-039-0500
Purpose and Statutory Authority

(1) Purpose. This rule prescribes standards for the approval, for insurance reimbursement purposes, of noninpatient programs that provide services for persons with a mental or nervous condition and that are not related to any county mental health program.

(2) Statutory Authority. These rules are authorized by ORS 430.065 and 743.556(3) and (4).

Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0510
Definitions

As used in these rules:

(1) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(2) "Certificate of Approval" means a Certificate of Approval as defined in OAR 309-012-0130 through 309-012-0220.

(3) "Day Treatment" or "Partial Hospitalization Program" means a non-residential program which provides an organized part-day program of mental health services to persons who spend only part of a 24 hour period in the facility. Services provided in a day treatment program are substantially similar to those provided in a partial hospitalization program.

(4) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(5) "DSM" means the current edition of the "**Diagnostic and Statistical Manual of Mental Disorders**," published by the American Psychiatric Association.

(6) "Facility" means a corporate or other entity which provides services for the treatment of mental or nervous conditions.

(7) "Non-Related Adult" means any person over 18 years of age who is not related by blood, marriage or living situation. Foster parents and adults co-habitating with a child may be considered to be related adults.

(8) "Outpatient Program" means a program that provides evaluation, treatment and rehabilitation on a regularly scheduled basis or in response to crisis in a setting outside an inpatient program, residential program, day treatment or partial hospitalization program.

(9) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(10) "Provider" means a program operated by either a licensed business or a corporation that provides services for mental or nervous conditions.

(11) "Qualified Mental Health Associate" means any person delivering services in a mental health program, under the direct supervision of a qualified mental health professional. The qualified mental health associate shall meet one of the following:

(a) Has a bachelor's degree in a mental health related field;

(b) Has a combination of one year's work experience and two years education, training or work experience in mental health.

(12) "Qualified Mental Health Professional" means any person, providing treatment services in a mental health program, supervised by a qualified supervisor. The qualified mental health professional shall have one of the following:

(a) A license to practice medicine in the State of Oregon;

(b) A graduate degree in Psychology;

(c) A graduate degree in Social Work;

(d) A graduate degree in Psychiatric Nursing and licensed in the State of Oregon; or

(e) A graduate degree in another mental health-related field.

(13) "Qualified Supervisor" means any person meeting the following qualifications:

(a) A medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon and who is board eligible for the practice of psychiatry;

(b) A psychologist licensed by the State Board of Psychologist Examiners;

(c) A registered nurse certified as a psychiatric nurse practitioner by the Oregon State Board of Nursing; or

(d) A clinical social worker licensed by the State Board of Clinical Social Workers.

(14) "Residential Program" means a program that provides room, board, and an organized full-day program of mental health services in a facility for six or more persons who do not require 24-hour nursing care.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0520
Eligible Providers

(1) Only providers as defined in OAR 309-039-0510(10) are eligible for approval under OAR 309-039-0500 through 309-039-0580. An eligible provider must:

(a) Control the office space, such as by owning, renting or leasing it;

(b) Control the intake to the program and determine which therapist provides assessment and treatment;

(c) Control all clinical records, including storage;

(d) Do all the billing and collect all fees, including deductibles and co-payments;

(e) Pay staff for clinical services provided; and

(f) Display the provider name on the premises so as to be clearly visible to clients.

(2) An individual operating as a private practitioner, whether or not a licensed business or corporation, is not eligible for approval under these rules.

Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0530
Approval Process

(1) Request for approval or renewal shall be submitted to the Division with an application form, materials specified in the application instructions and a check or money order in the amount of $100 payable to the Division. This application fee shall be non-refundable:

(a) After the Division has approved the written application materials specified in the application instructions, the applicant shall submit a check or money order payable to the Division in the amount of $350 for certification review. This certification fee shall be non-refundable if a certification review has been conducted, irrespective of whether the provider is issued a Certificate of Approval;

(b) Any provider submitting an application for approval or renewal after the effective date of this rule shall pay the application and certification fees;

(c) The fees shall be increased biennially at the same rate as approved by the Legislative Assembly or the Emergency Board for other services and programs of the Division.

(2) A Certificate of Approval, valid for up to three years, shall be issued to the provider when the administrative and certification reviews of the program by the Division indicate the provider is in compliance with the applicable parts of OAR 309-039-0500 through 309-039-0580. The Certificate may be for a period of time shorter than three years if the provider is not in full compliance with these rules.

(3) A Certificate of Approval is not transferable or applicable to any location, facility, or management other than that indicated on the Certificate of Approval.

(4) The award, renewal, and duration of Certificates of Approval as well as periodic and interim reviews, establishment of conditions, denial, revocation and hearings shall comply with OAR 309-012-0130 through 309-012-0220 (Certificate of Approval rule).

Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0540
General Standards

Each provider is required to meet the following administrative standards:

(1) Organization. There shall be an up-to-date organization chart showing the lines of authority and responsibility for management of the organization and clinical supervision of treatment staff.

(2) Policy and Procedures. There shall be written statements of policies and procedures as are necessary and useful to enable the program to accomplish its service objectives and to meet the requirements of these rules and other applicable standards and rules.

(3) Staff Qualifications. Providers shall use only qualified supervisors, qualified mental health professionals and qualified mental health associates who meet OAR 309-039-0510(11) through (13):

(a) Only qualified supervisors and qualified mental health professionals shall provide individual, group and family therapy;

(b) Qualified mental health associates shall only provide skill training, socialization and case management services. Qualified mental health associates may participate in the provision of group therapy if a qualified supervisor or a qualified mental health professional is present.

(4) Client Eligibility for Service. Each provider shall have a written policy regarding client eligibility for service which includes the following:

(a) Mental health services shall not be denied any person on the basis of race, color, creed, sex, handicap, national origin or duration of residence;

(b) No person shall be denied services or be discriminated against on the basis of age unless predetermined clinical or program criteria for service restrict the service to specific age groups.

(5) Client Rights. Each provider shall have written policies and procedures to assure the following:

(a) Protection of client privacy and dignity;

(b) Confidentiality of records consistent with state and federal law as described in the Mental Health and Developmental Disability Services Division's "**Handbook on Confidentiality**";

(c) The earliest possible involvement of the client in planning the service through the provision of information, presented in terms easily understandable to the client, which explain the following:

(A) The training or treatment to be undertaken;

(B) Alternative training or treatment methods available, if any; and

(C) Risks that may be involved in the training or treatment, if any.

(d) The client's or guardian's right to refuse service unless otherwise ordered by a court; and

(e) That the client is provided with written information concerning the agency fee policies at the earliest possible time and in terms easily understandable to the client.

(6) Treatment and Assessment Services. Each provider shall provide for each client admitted:

(a) Preliminary planning that includes:

(A) An initial assessment of client condition that justifies a diagnostic impression of mental or nervous condition completed within seven working days of admission; and

(B) A preliminary treatment plan completed within seven working days of admission, that describes the services to be delivered to the client while a complete psychosocial assessment and treatment plan are being developed.

(b) A psychosocial assessment, including a problem list, completed within 15 days of admission, or if a residential program within seven days of admission, resulting in a DSM diagnosis which confirms or denies a mental or nervous condition; and

(c) A treatment plan developed from the problem list, within 15 days of admission, that is agreed to and is signed by the client and includes an individualized regimen of treatment services which addresses the mental or nervous condition.

(7) Client Records. A record shall be maintained for each client admitted. The record shall contain the following:

(a) Client identification;

(b) Client consent to treatment;

(c) A preliminary plan, as described in subsection (6)(a) of this rule;

(d) A psychosocial assessment as described in subsection (6)(b) of this rule which includes:

(A) Presenting problems and current psychiatric history;

(B) Alcohol/drug use problems history;

(C) History of psychological problems and past psychiatric history;

(D) Family and interpersonal history;

(E) Education, employment, and vocational history;

(F) Legal history;

(G) Medical history and information;

(H) Problem list;

(I) DSM diagnoses and summary of the justification for each diagnosis; and

(J) Treatment recommendations.

(e) A treatment plan as described in subsection (6)(c) of this rule that addresses the treatment of the mental or nervous conditions and which includes measurable objectives for each of the Axis I diagnoses, type of intervention activities and target dates for meeting objectives;

(f) Progress notes relating to specific problems addressed in the treatment plan;

(g) Client consent for releases of information when appropriate; and

(h) For discharged clients, a discharge/transfer summary which includes an aftercare plan.

(8) Retention of Records. Client records shall be retained for a minimum of seven years.

(9) Personnel Records. Each provider shall maintain a personnel file for each employee or contractor providing treatment services or clinical supervision. The personnel file shall contain a written job description, copies of degrees and licenses, and a current resume that demonstrates qualifications to perform job duties.

(10) Financial Records. Each provider shall maintain financial records that demonstrate payments for service are made to the provider and not to an individual.

(11) Quality Assurance. Each provider shall have policies and procedures for the operation of a routine quality assurance program designed to monitor and evaluate objectively and systematically the quality and appropriateness of client treatment services, pursue opportunities to improve client treatment services, and resolve identified problems. Each provider shall:

(a) Have a written plan for the quality assurance program that describes a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services provided by the provider; and

(b) Conduct utilization reviews of client treatment services and aftercare plans that address client progress in the resolution of the mental or nervous condition, medical issues pertinent to the treatment of the mental or nervous condition, and functioning in the community following discharge from treatment.

(12) Treatment of Children and Adolescents. If a provider offers services to children or adolescents, then in addition to the requirements of OAR 309-039-0500 through 309-039-0580, the provider must meet the following standards:

(a) Minors 14 years of age or older may consent to outpatient services if provided by a physician licensed in the State of Oregon, licensed psychologist, certified nurse practitioner, or licensed social worker as provided for in ORS 109.675. Minors 15 years or older may consent to residential, partial hospitalization or day treatment services if provided by a physician licensed in the State of Oregon as provided by ORS 109.640. Providers shall provide for the earliest feasible involvement of the parents or guardians in the treatment plan consistent with the clinical requirement of the minor as provided under ORS 109.695;

(b) Children and adolescents are prohibited from receiving services conjointly with unrelated adults. Providers that offer services to both children and adolescents, and adults shall provide services to children and adolescents in areas within the facility, separate from areas in which adults are treated;

(c) As evidenced by previous work experience, academic background, and in-service or other training, the qualified supervisor, qualified mental health professional, and qualified mental health associates shall demonstrate a working knowledge of the following:

(A) The normal process of child and adolescent growth and development;

(B) Dysfunctional families and family systems counseling; and

(C) Mental and nervous conditions of childhood and adolescence.

(d) Treatment plans, in addition to the requirements of OAR 309-039-0540(7)(e), shall:

(A) Be developed in cooperation with the child or adolescent and the family, and other involved professionals as appropriate; and

(B) Include the involvement of the child's or adolescent's "significant others" in treatment; i.e., individuals, schools, agencies, etc.

(13) Grievance Procedure. Each provider shall have a written policy and procedure regarding client grievances. Each client shall be given a copy of the grievance policy and procedure at the time of admission or the grievance policy and procedure shall be posted in all waiting rooms.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0550
Standards for Mental Health Outpatient Programs

Each provider operating a mental health outpatient program shall comply with OAR 309-039-0500 through 309-039-0540.

Stat. Auth.: ORS 411
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89

309-039-0560
Standards for Mental Health Partial Hospitalization and Day Treatment Programs

In addition to OAR 309-039-0500 through 309-039-0540, each provider operating a mental health partial hospitalization or day treatment program shall comply with the following standards:

(1) Facility standards. The facility shall meet all applicable state and local fire, safety, and health standards.

(2) Treatment standards. Each provider shall provide four hours a day, five days a week, structured treatment activities which address the mental or nervous condition and which, in addition, includes the following services each week:

(a) Daily group therapy for mental and nervous conditions;

(b) Individual counseling with a primary therapist two times per week;

(c) Family therapy, as appropriate to the individual needs of the client;

(d) Psychotropic medication management or monitoring, as appropriate to the individual needs of the client; and

(e) Skills training, vocational training, socialization or structured recreational/physical fitness activities.

Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0570
Standards for Mental Health Residential Programs

In addition to meeting OAR 309-039-0500 through 309-039-0540 each provider operating a mental health residential program shall meet the following standards:

(1) Facility standards. Each provider shall meet OAR 309-035-0100 through 309-035-0190.

(2) Treatment standards. Each provider shall provide eight hours of structured services out of every 12 hours from 8 a.m. to 8 p.m. which, each week, includes:

(a) Daily group therapy which addresses the mental or nervous condition;

(b) Individual counseling which addresses the mental or nervous condition with a primary therapist two times per week;

(c) Family therapy, as appropriate to the individual needs of the client;

(d) Psychotropic medication management or monitoring, as appropriate to the individual needs of the client;

(e) One hour per day of structured recreational/physical fitness activities; and

(f) Structured skills training, vocational training, or socialization activities.

(3) Treatment standards for children and adolescents:

(a) Each provider shall comply with OAR 309-035-0100 through 309-035-0190;

(b) Each residential facility serving children or adolescents shall meet the standards described by OAR 412-024-0100 through 412-024-0225, Standards for reviewing, inspecting and licensing those private child caring agencies which are for residential care and treatment services for children and which are subject to the provisions of ORS Chapter 418, for licensure by the Children's Services Division.

(4) Staffing standards. Each provider shall:

(a) Provide staff coverage 24 hours-a-day, seven days-a-week;

(b) Employ sufficient qualified mental health professionals to maintain a maximum caseload of no more than eight clients;

(c) Have a mental health associate on site, and awake, from 8 p.m. to 8 a.m.; and

(d) Have available a mental health professional on-call from 8 p.m. to 8 a.m.

Stat. Auth.: ORS 411
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89

309-039-0580
Variance

A variance from these rules may be granted to a provider in the following manner:

(1) A provider requesting a variance shall submit, in writing, to the Division:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance, if appropriate, with the section of the rule from which the variance is sought.

(2) The Assistant Administrator or designee of the Office of Mental Health Services shall approve or deny the request for variance.

(3) The Division shall forward the decision and reasons therefor to the provider requesting the variance. This notice shall be given the provider within 30 days of receipt of the request by the Division.

(4) Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

Stat. Auth.: ORS 411, 430.065, 743.556(3) & 743.556(4)
Stats. Implemented:
Hist.: MHD 2-1989(Temp), f. 3-13-89, cert. ef. 3-14-89; MHD 4-1989, f. & cert. ef. 8-25-89; MHD 1-1993, f. 2-24-93, cert. ef. 2-26-93

309-039-0700
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for implementation of a registration pilot project in Jackson and Josephine Counties. All rules are limited to this geographic area during the length of the pilot project.

(2) Statutory Authority. These rules are authorized by ORS 430.041 to carry out the provisions of the 1997 Oregon Law 618, sections 1-5.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0710
Definitions

As used in these rules:

(1) "Assessment" means the determination of a person's need for services. It involves the collection and evaluation of data pertinent to the person's mental and physical history and current problem(s) obtained through interview, observation, and record review. The assessment concludes with one of the following:

(a) Documentation of a DSM Diagnosis providing the clinical basis for a written treatment plan; or

(b) A written statement that the person is not in need of services. Other disposition information such as to whom the person was referred is included in the clinical record. The assessment is conducted by a QMHP, Registered Nurse (R.N.), or other qualified professional.

(2) "Assignment" as defined by Oregon State Board of Nursing OAR 851-047-0010(3) means that an R.N., or Licensed Practical Nurse (L.P.N.), at the discretion of the R.N., authorizes an unlicensed person to perform a basic task of client care with knowledge that the unlicensed person has been taught the task and is competent in performing the task. Assignment may require that a licensed nurse periodically supervise and evaluate the unlicensed person performing the basic task of client care. The need for and intervals of supervision and evaluation is at the discretion of the R.N. The process of assignment and delegation is delineated and explained in its entirety by the Oregon State Board of Nursing in OAR 851, division 47 and shall be followed.

(3) "Basic Care Tasks" means procedures that do not require the education or training of an R.N. or L.P.N., but that cannot be performed by the client independently. Basic care tasks also means procedures that may be directed by the client. These basic tasks include, but are not limited to, activities of daily living and administration of non-injectable or subcutaneous medications. These tasks are comparable to Certified Nursing Assistant functions.

(4) "Counseling Groups" means planned treatment to remediate significant impairments in the client's functioning that are the result of a principal mental or emotional disorder identified by a mental health assessment. Group counseling is the treatment of three or more unrelated persons with similar therapeutic issues. It is individualized to meet specific goals and measurable objectives in the treatment plan. The intended outcome of group counseling for a child is to achieve and maintain the best possible, developmentally appropriate, level of functioning. The intended outcome of group counseling for an adult is to manage, reduce, or resolve the identified mental health problems thereby allowing the consumer to function more independently and competently in daily life.

(5) "Delegation" as defined by Oregon State Board of Nursing OAR 851-047-0010(8) means an R.N. authorizes an unlicensed person to perform special tasks of client/nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed person, teaching the task and ensuring supervision. The process of assignment and delegation is delineated and explained in its entirety by the Oregon State Board of Nursing in OAR 851, division 47 and shall be followed.

(6) "Diagnosis" means the principal mental disorder listed in the most recently published edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**, that is the medically appropriate reason for clinical care and the main focus of treatment for a client. The principal diagnosis is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment.

(7) "Division" means the Mental Health and Developmental Disability Services Division.

(8) "Endorsement" means a process of registration based on registration, certification, or licensure in another state or jurisdiction.

(9) "Health Care Provider" means a professional such as physician, R.N., social worker, qualified mental health professional, or psychologist meeting the qualifications, and operating under the definitions, of their licensing boards.

(10) "Interdisciplinary Team" means the group of people designated to provide services to mental health and developmentally disabled consumers and may include multiple disciplines or agencies.

(11) "Mental Health Assessment" or "Evaluation" means the written assessment by a QMHP of a consumer's mental status and emotional, cognitive, family, developmental, behavioral, social, recreational, physical, nutritional, school or vocational, substance abuse, cultural and legal functioning, concluding with a completed DSM five-axes diagnosis, clinical formulation, prognosis for treatment, treatment recommendations and plan. Evaluation is used to determine the need for mental health services and to develop or update a consumer's individual plan of care. Evaluation includes the collection and analysis of pertinent information through interview with the consumer, family and other relevant persons; observation; and psychological and neuropsychological testing when indicated.

(12) "Mental Status Examination" means the face-to-face assessment by a QMHP of a person's mental functioning that includes descriptions of appearance, behavior, speech, mood and affect, suicidal/homicidal ideation, thought processes and content, and perceptual difficulties including hallucinations and delusions. Cognitive abilities are also assessed and include orientation, memory, concentration, general knowledge, abstraction abilities, judgment and insight.

(13) "Physician" means a person licensed to practice under ORS Chapter 677.

(14) "Perform Interventions" means the execution of specific tasks which are detailed in the consumer's care plan and are performed under the supervision of a qualified healthcare provider.

(15) "Qualified Mental Health Professional (QMHP)" means a person meeting the following minimum qualifications:

(a) Graduate degree in psychology;

(b) Bachelor's degree in nursing and licensed by the State of Oregon;

(c) Graduate degree in social work;

(d) Graduate degree in behavioral science field;

(e) Graduate degree in recreational, art, or music therapy; or

(f) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(g) Whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM Diagnosis; write and supervise a treatment plan; conduct a comprehensive mental health assessment; and provide individual therapy, family, and/or group therapy within the scope of his or her practice.

(16) "RMHT" means Registered Mental Health Technician.

(17) "Registered Nurse" or "R.N." means a person licensed as a registered nurse under ORS 678.

(18) "Skill Development Groups" means planned treatment focused on development of a specific life skill. A group is comprised of

three or more unrelated persons with similar goals or concerns. It is individualized to meet specific goals and measurable objectives in the treatment plan. Examples include, but are not limited to: Hygiene, appropriate behavior in defined settings, communication, cleaning, personal finance, or cooking.

(19) "Subcutaneous Injectable Medication" means a medication administered through injection into the space beneath the skin but not to include medication administered through injection into the skin (intradermal) or injection into muscular tissue (intramuscular).

(20) "Supervision" means the documented oversight by a QMHP of mental health treatment services excluding medication administration. Documented oversight of medication administration shall be provided by an R.N., L.P.N., or Licensed Nurse Practitioner. The supervisor shall periodically monitor, by direct observation, the Mental Health Technician's skill and ability to perform a task, reassess the consumer, and assess the need for continued supervision.

(21) "Treatment Plan" means a planned, medically appropriate, individualized program of interactive medical, psychological, or rehabilitative procedures, experiences, and/or activities designed to rehabilitate, relieve, or minimize mental, physical, or emotional disorders identified through an assessment.

[[Publications: Publications referenced are available from the agency.]]
Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0720
Authorized Duties

Registered Mental Health Technicians within the limitations of their training and qualifications in accordance with Oregon Law shall:

(1) Actively participate as a member of an interdisciplinary team by:

(a) Collaborating with the consumer and other team members in setting goals, establishing plans, and making decisions regarding the care of the consumer;

(b) Ensuring the input of the consumer is included in this process whenever possible;

(c) Assisting in the treatment planning process in establishing and revising individualized care plans;

(d) Respecting other team members and their contributions to the care of the consumer;

(e) Seeking consultation with others when needed and, in turn, providing information when appropriate; and

(f) Coordinating knowledge and skills with other members of the interdisciplinary team.

(2) Perform interventions as defined in these rules that reflect a respect for the variety of human needs, abilities and interests, and include interventions for physical, developmental and mental health. The RMHT shall work under the supervision as defined in these rules and provide interventions as specified in the consumer's plan of care within their authorized duties. The RMHT shall assist in the promotion, maintenance or restoration of health, and prevention of illness, by:

(a) Performing interventions only as specified by the treatment plan and that are within the scope of authorized duties of the RMHT;

(b) Documenting interventions by written records;

(c) Assisting in reviewing the outcome of interventions;

(d) Using acquired basic health care skills to meet consumer's health care needs, assist in the maintenance of consumer's optimal mental and physical health, and obtain assistance from other healthcare providers when appropriate; and

(e) Acting as the advocate of the consumer when necessary to facilitate the achievement of health.

(A) RMHT interventions can include the performance of basic care tasks as assigned or delegated by an R.N. pursuant to OAR 851-047-0000 to 851-047-0030.

(B) In addition, RMHTs can:

(i) Assist with the intake process by collecting demographic data, medical history including mental health history, current status including vital signs, height, weight, allergies, medical conditions, surgeries, substance use history, and other relevant history but does not include performing mental status examinations or comprehensive mental health assessments;

(ii) Serve as a liaison between consumer and other health care professionals;

(iii) Administer routine oral and subcutaneous injectable medications only as assigned or delegated by an R.N. pursuant to OAR 851-047-0000 to 851-047-0030;

(iv) Provide skill development groups with individuals and groups;

(v) Assist with counseling groups led by a QMHP, R.N., or other qualified professional;

(vi) Supervise recreational activities and special events;

(vii) Assist consumers with community outings;

(viii) Assist consumers with money management;

(ix) Conduct home visits to monitor activities and orientation level;

(x) Use effective communication skills; and

(xi) Report changes in consumer condition to consumer and responsible persons such as nurses, physicians, case managers, QMHP, and others.

(3) Participate in the on-going evaluation of consumer responses by:

(a) Making observations and collecting data related to specific consumers;

(b) Sharing observations and data with other members of the interdisciplinary team; and

(c) Documenting observations and data in consumer file.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0730
Approval of Training Program

(1) Training programs may apply to the Division for approval to offer mental health technician training.

(2) The program shall meet the following criteria for approval:

(a) Be at least one year in length and include a minimum of 71 total quarter hours of course work of which 27 quarter hours shall be lab and clinical courses; and

(b) Contain content and outcome objectives that adequately train the applicant with the ability to perform the authorized duties defined in these rules.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0740
Qualifications for Registration

(1) For purposes of the pilot project the applicant must work or plan to work in Jackson or Josephine County. An applicant for mental health technician registration shall have the following qualifications:

(a) Be at least 18 years of age;

(b) Have successfully completed an approved general education course of study through the 12th grade or the equivalent thereof as determined by the Division;

(c) Have successfully passed a criminal offender records check as required under OAR 407-007-0200 through 407-007-0380 and includes a fitness determination decision made by the Division based on this criminal offender records check information; and

(d) Have successfully completed a course of study in an approved Oregon program for mental health technician, or equivalent to the training program requirements in Oregon, and approved by the Division.

(e) The applicant shall have graduated from the approved or equivalent training program within the past five years, or shall have worked a minimum of 960 hours in the last three years in a role equivalent to the authorized duties. The Division shall also review documentation of past and current job duties and supervisor letters of recommendation as part of the evidence of qualification at time of application.

(2) All applicants for registration as a mental health technician shall furnish evidence to the Division that the applicant has satisfactorily completed the requirements of registration listed above and paid the required fees. The Division holds the sole authority to grant registration to an individual.

(3) In addition to the requirements above, an applicant for endorsement shall provide written documentation that the applicant holds a valid, unencumbered license, certification, or registration as a mental

health or psychiatric technician in another state which has requirements substantially equivalent to those adopted in Oregon.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0750
Application Process for Registration

The application process for Registration of Mental Health Technicians shall be governed by the following rules:

(1) An individual shall make application on a form provided by the Division.

(2) The Division shall notify the applicant of the decision on each application by written communication and, in the event of denial, shall state the reasons.

(3) An individual whose application has been denied shall have access to due process pursuant to the Oregon Administrative Procedures Act, ORS Chapter 183, and may request a contested case hearing. A request for a hearing must be submitted to the Division in writing within 60 days of denial. The Division shall schedule a hearing and notify the applicant of the time and location of the hearing. If a request for hearing is not made within 60 days, the right to a hearing will be waived unless the applicant can establish good cause for making a late request.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0760
Fees

The Division shall collect the following fees for application, registration, renewal of registration, and delinquent renewal fees:

(1) The application fee for registration shall be $50.00.

(2) The registration period will cover one calendar year. If the applicant applies for registration after September 1 the registration period will include the following calendar year.

(3) The fee for renewal of registration shall be $50.00.

(4) The Division shall impose a delinquent renewal fee of $25.00 for registrations renewed after January 1. After March 1 the Division shall treat a registration as lapsed.

(5) Cost of a duplicate registration certificate: $10.00.

(6) Written verification of registration: $10.00.

(7) All fees are non-refundable.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0770
Renewal of Registration

Renewal of registration may be obtained upon submission of a form provided by the Division. Each registrant shall notify the Division in writing of a change in name or address within 30 days of the change. Renewal fees are indicated above.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0780
Continuing Education

Continuing education may be required to renew registration and the Division should be contacted for further information regarding this process. Registrants shall not be required to comply with this requirement during the first calendar year in which they become registered.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

309-039-0790
Suspension, Denial or Revocation of Registration

(1) All forms of written communication shall be sent by the Division to the registrant's address on file with the Division. The Division may suspend, revoke, or deny registration to applicants for any one of the following reasons:

(a) Failure to provide accurate information when applying for registration;

(b) Failure to notify the Division of name, address, and employment changes within 30 days;

(c) Evidence of conviction for any crime listed in OAR 407-007-0280 or a fitness determination that a registrant is not qualified to be a Mental Health Technician as set forth in OAR 407-007-0300 and 407-007-0320;

(d) The registrant has been negligent in performing the authorized duties of mental health technician;

(e) The registrant is practicing beyond the scope of the authorized duties;

(f) The registrant has violated one or more of the administrative rules of the Division pertaining to registered mental health technicians;

(g) The registrant has violated one or more of the administrative rules applicable to their practice setting;

(h) Use of any controlled substance or intoxicants to an extent or in a manner dangerous or injurious to the registrant or others or to an extent that such use impairs the ability to conduct safely the duties of a mental health technician; or

(i) A physical or mental condition that makes the certificate holder unable to perform safely the duties of a mental health technician.

(2) In determining the appropriate sanction, the Division may consider circumstances that aggravate or mitigate the conduct resulting in disciplinary action.

(3) If the Division determines to suspend, revoke, or deny registration of a mental health technician the registrant shall be notified of the decision by written communication and the Division shall state the reasons.

(4) An individual whose registration has been suspended, revoked, or denied shall have access to due process pursuant to the Oregon Administrative Procedures Act, ORS Chapter 183, and may request a contested case hearing. A request for a hearing must be submitted to the Division in writing within 90 days of denial. The Division shall schedule a hearing and notify the applicant of the time and location of the hearing. If a request for hearing is not made within 90 days the right to a hearing will be waived unless the applicant can establish good cause for making a late request.

Stat. Auth.: ORS 430.041
Stats. Implemented: OL 1997, Ch. 618
Hist.: MHD 1-1999, f. 2-24-99, cert. ef. 3-1-99

DIVISION 40

ADULT FOSTER HOMES

Abuse Reporting and Protective Services in Community Programs and Community Facilities

309-040-0300
Purpose and Scope

(1) Purpose. These rules prescribe the standards and procedures for the provision of care and services to residents with mental illness in the Department of Human Services (DHS), Health Services (HS), Office of Mental Health and Addiction Services (OMHAS) adult foster homes as a condition for licensure and payment. The care and services are designed to promote the resident's right to independence, choice and decision making while providing a safe, secure, homelike environment. The resident's needs will be addressed in a manner, which enables the resident to function at the highest level of independence possible.

(2) Scope. These rules apply to adult foster homes for five or fewer residents.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0000, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0305
Definitions

As used in these rules the following definitions apply:

(1) "Abuse" includes but is not limited to:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or provider, or other caregiver and the adult. For situations other than those involving an employee, provider, or other caregiver and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

(e) Neglect that leads to physical harm or significant mental injury through withholding of services necessary to maintain health and well being;

(f) Abuse does not include spiritual treatments by a duly accredited practitioner of a recognized church or religious denomination when voluntarily consented to by the adult.

(g) Abuse also includes:

(A) Failure to act and/or neglect that results in imminent danger of causing physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to failure by a provider or staff to provide an adult with adequate food, clothing, shelter, medical care, supervision, or through tolerating or permitting abusive conduct toward an adult by any other person. However, no person will be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment;

(B) Verbal mistreatment by subjecting an adult to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation and threatening injury or withholding of services or supports, including implied or direct threat of termination of services;

(C) Placement of restrictions on a resident's freedom of movement. Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan;

(D) Financial exploitation by a caregiver including, but not limited to, unauthorized rate increases, borrowing from or loaning money to residents, witnessing wills in which a caregiver is beneficiary, adding caregiver's name to resident's bank accounts or other personal property without approval of the resident or his/her guardian or conservator and the PCP team; and

(E) Inappropriate expenditure of a resident's personal funds, theft of a resident's personal funds, use of a resident's personal funds for caregivers own benefit, commingling of a resident's funds with caregiver or other resident's funds, or a caregiver becoming guardian or conservator.

(2) "Abuse Investigation and Protective Services" means an investigation and any subsequent services or supports necessary to prevent further abuse as required by ORS 430.745 to 430.765 and, OAR 410-009-0050 through 410-009-0160, or any other rules established by the Department applicable to allegations of abuse of residents of an Adult Foster Home licensed by OMHAS.

(3) "Activities of Daily Living (ADL)" are those individual skills necessary for a resident's Continued well being including eating/nutrition, dressing, personal hygiene, mobility, and toileting.

(4) "Administration of Medication" means administration of medicine or a medical treatment to a resident as prescribed by a Licensed Medical Practitioner.

(5) "Adult Foster Home (AFH)" means any home licensed by the Department of Human Services (DHS), Office of Mental Health and Addiction Services (OMHAS) in which residential care is provided to five or fewer adults who are not related to the provider by blood or marriage as described in ORS 443.705 through 443.825. For the purpose of these rules, if an adult family member receives care, he/she must be included as one of the residents within the total license capacity of the home. A home or person that advertises, including word-of-mouth advertising, to provide room, board, and care and services for adults, is deemed to be an Adult Foster Home. For the purpose of these rules, an Adult Foster Home does not include facilities referenced in ORS 443.715(1)(2)(3)(4).

(6) "Applicant" means any person or entity that makes an application for a license that is also the owner of the business.

(7) "Assessment" means an evaluation of a resident and the resident's level of function completed by a case manager and provides the basis for the development of the resident's Personal Care Plan.

(8) "Authorized Department Representative" means an employee of the Department of Human Services (DHS), Office of Mental Health and Addiction Services (OMHAS) or the designee of the local Community Mental Health Program.

(9) "Behavioral Interventions" means those interventions that will modify the resident's behavior or the resident's environment.

(10) "Bill of Rights" means civil, legal or human rights afforded to Adult Foster Home residents, which are in accord with those rights afforded to all other U.S. citizens, including but not limited to those rights delineated in the Adult Foster Home Bill of Rights as described in OAR 309-040-0390(7).

(11) "Board of Nursing Rules" means the standards for Registered Nurse Teaching and Delegation and assignments to Unlicensed Persons according to the statutes and rule of the Oregon State Board of Nursing, chapter 851, division 47, ORS 678.010 to 678.445.

(12) "Care" means the provision of but is not limited to services of room, board, services and assistance with activities of daily living, such as assistance with bathing, dressing, grooming, eating, money management, recreational activities, and medication management. Care also means services that promote maximum resident independence and enhance quality of life.

(13) "Case Management" means identified services provided by qualified persons to residents by local, regional or state allied agencies or other service providers. Case management includes advocating for the resident's treatment needs, providing assistance in obtaining entitlements based on mental or emotional disability, accessing housing or residential programs, coordinating services including mental health treatment, educational or vocational activities, and arranging alternatives to inpatient hospital services.

(14) "Case Manager" means a person employed by a local, regional, or state allied agency approved by OMHAS to provide case management services. In accordance with OAR 309-032-0545(2)(g-j), Standards for Adult Mental Health Services, when a resident resides in a Adult Foster Home, the case manager will assist in development of the Personal Care Plan. Additionally, the case manager must evaluate the appropriateness of services in relation to the consumer's assessed need and review the Personal Care Plan every 180 days.

(15) "Community Mental Health Program (CMHP)" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Department of Human Services, Office of Mental Health and Addiction Services (OMHAS).

(16) "Compensation" means payments made by or on behalf of a resident to a provider in exchange for room and board, care and services, including services described in the resident's Personal Care Plan.

(17) "Complaint Investigation" means an investigation of any allegation that a provider has taken action, which is perceived as contrary to law, rule, or policy but does not meet the criteria for an abuse investigation.

(18) "Condition" means a provision attached to a new or existing license, which limits or restricts the scope of the license or imposes additional requirements on the licensee.

(19) "Contested Case Hearing" means an arbitrated hearing resulting in a directed or recommended action. The hearing is held at the request of the provider or OMHAS in response to an action, sanction, or notice of finding issued by OMHAS that would result in the loss of license of the provider or other sanctions that would adversely affect the license of the provider. The hearing group is composed of:

(a) The provider and if the provider chooses, the provider's attorney;

(b) The Office of Mental Health and Addiction Services as represented by the Attorney General's Office; and

(c) The Office of Administration Hearings Administrative Law Judge.

(20) "Contract" means a written agreement between a provider and the Department to provide room and board, care and services for compensation for residents of a licensed Adult Foster Home.

(21) "Controlled Substance" means any drug classified as schedules one through five under the Federal Controlled Substance Act.

(22) "Criminal History Check (CHC)" means the Oregon Criminal History Check and when required, a National Criminal History check and/or a State-Specific Criminal History check, and the process-

es and procedures required by the rules OAR 407-007-0200 through 407-007-0380 Criminal History Check Rules.

(23) "Day Care" means care and services in an Adult Foster Home for a person who is not a resident of the Adult Foster Home. Children under the age of five living in the Adult Foster Home are included in the licensed capacity of the home.

(24) "Declaration for Mental Health Treatment" means a document that states the consumer's preferences or instructions regarding mental health treatment as defined by ORS 127.700 through 127.737.

(25) "Department" means the State of Oregon, Department of Human Services.

(26) "Director" means the Director of the Department of Human Services or that person's designee.

(27) "Discharge Summary" means a document that describes the conclusion of the planned course of services described in the resident's individualized personal care plan, regardless of outcome or attainment of goals described in the resident's individualized personal care plan. In addition, the discharge summary addresses resident's monies, financial assets and monies, medication and personal belongings at time of discharge.

(28) "Exempt Area" means a county agency that provides similar programs for licensing and inspection of Adult Foster Homes which the Director finds equal to or superior to the requirements of ORS 443.705 to 443.825 and which has entered into an agreement with the Department to license, inspect, and collect fees according to the provisions of ORS 443.705 to 443.825.

(29) "Family Member" for the purposes of these rules, means a husband or wife, natural parent, child, sibling, adopted child, domestic partner, adopted parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew, or first cousin.

(30) "Home" means the Adult Foster Home.

(31) "Homelike Environment" means an Adult Foster Home setting, which promotes the dignity, safety, independence, security, health and comfort of residents through the provision of personalized care and services to encourage independence, choice, and decision making of the residents.

(32) "House Rules" means those written standards governing house activities developed by the provider and approved by the Department or designee. These standards must not conflict with the Adult Foster Home Bill of Rights.

(33) "Incident Report" means a written description and account of any occurrence including but not limited to, any injury, accident, acts of physical aggression, use of physical restraints, medication error, any unusual incident involving a resident or the home and/or providers.

(34) "Informed Consent for Services" means that the services to be provided by the Adult Foster Home provider to the person have been explained to the person and guardian, if applicable, and explained in a manner that they may comprehend.

(35) "Initial Personal Care Plan (IPCP)" means a written document developed for a resident within 24 hours of admission to the home. The document must address the care and services to be provided for the resident during the first 30 days or less until the Personal Care Plan can be developed. At a minimum the IPCP must contain goals that address the following: Immediate health care support needs, medication management issues, safety and supervision needs, Activities of Daily Living that the resident needs assistance with completing as well as any pertinent information as required by the case manager or their designee at the time of the admission. The provider must develop an Initial Personal Care Plan (IPCP) within 24 hours of admission to the Adult Foster Home.

(36) "Level One Adult Foster Home" means an Adult Foster Home licensed by the Office of Mental Health and Addiction Services to provide care and services to individuals with severe and persistent mental illness, who may also have limited medical conditions.

(37) "License" means a document issued by the Department to applicants who are determined by the Department or designee to be in substantial compliance with these rules.

(38) "Licensed Medical Practitioner (LMP)" means any person who meets the following minimum qualifications as documented by the CMHP or designee and holds at least one of the following educational degrees and a valid license:

(a) Physician licensed to practice in the State of Oregon; or

(b) Nurse practitioner licensed to practice in the State of Oregon.

(39) "Licensee" means the person or entity to whom a license is issued and whose name(s) is on the license.

(40) "Local Mental Health Authority (LMHA)" means the county court or board of county commissioners of one or more counties who choose to operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation which directly contracts with the Department to operate a CMHP for that county.

(41) "Mandatory Reporter" means any public or private official who, while acting in an official capacity, comes in contact with and has reasonable cause to believe that the adult has suffered abuse, or that any person with whom the official contact while acting in an official capacity, has abused the adult. Pursuant to ORS 430.765(2) psychiatrists, psychologists, clergy, and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to 40.295.

(42) "Medication" means any drug, chemical, compound, suspension or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(43) "Mental or Emotional Disturbances (MED)" means a disorder of emotional reactions, thought processes, or behavior that results in substantial subjective distress or impaired perceptions of reality or impaired ability to control or appreciate the consequences of the person's behavior and constitutes a substantial impairment of the person's social, educational, or economic functioning. Medical diagnosis and classification must be consistent with the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV). As used in these rules, this term is functionally equivalent to "serious and persistent mental illness."

(44) "National Criminal History Check" means obtaining and reviewing criminal history outside Oregon's borders. This information may be obtained from the Federal Bureau of Investigation through the use of fingerprint cards and from other criminal information resources in accordance with OAR 407-007-0200 through 407-007-0380 Criminal History Check Rules.

(45) "Neglect" means an action or inaction that leads to physical harm through withholding of services necessary to maintain health and well-being. For purposes of this paragraph, "neglect" does not included a failure of the state or a community program to provide services due to a lack of funding available to provide the services.

(46) "Nurse Practitioner" means a registered nurse who has been certified by the board as qualified to practice in an expanded specialty role within the practice of nursing.

(47) "Nursing Care" means the practice of nursing by a licensed nurse, including tasks and functions relating to the provision of nursing care that are delegated under specified conditions by a registered nurse to persons other than licensed nursing personnel, which is governed by ORS chapter 678 and rules adopted by the Oregon State Board of Nursing in OAR Chapter 851.

(48) "Nursing Delegation" means that a registered nurse authorizes an unlicensed person to perform special tasks of client/nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed person, teaching the task and ensuring supervision.

(49) "Personal Care Plan (PCP)" means a written plan outlining the care and services to be provided to a resident. The PCP is based upon the review of current assessment, referral, observations, resident preference, and input from members of the Personal Care Plan Team. The plan identifies the care, services, activities, and opportunities to be provided by the caregiver to promote the resident's recovery and independence.

(50) "Personal Care Plan Team (PCP Team)" means a group composed of the resident, the case manager or other designated representative CMHP representative, the provider and or resident manager, and others needed including the resident's legal guardian, representatives of all current service providers, advocates or others determined appropriate by the resident receiving services. If the resident is unable or does not express a preference, other appropriate team membership must be determined by the PCP team members.

(51) "Personal Care Services" means services prescribed by a physician or other designated person in accordance with the individual's plan of treatment. The services are provided by a caregiver that is qualified to provide the service and is not a member of the individual's immediate family. For those Adult Foster Home individuals who are Medicaid eligible, Personal Care services are funded under Medicaid.

(52) "Practice of Registered Nursing" means the application of knowledge drawn from broad in-depth education in the social and physical sciences in assessing, planning, ordering, giving, delegating, teaching and supervising care which promotes the person's optimum health and independence.

(53) "Provider" means the person or entity licensed to operate and is responsible for the daily operation of the Adult Foster Home. "Provider" does not include the owner or lessor of the building in which the adult foster home is situated unless the owner or lessor is also the operator of the Adult Foster Home.

(54) "Psychiatric Security Review Board (PSRB)" means the Board consisting of five members appointed by the Governor and subject to confirmation by the Senate under Section Four, Article 111 of the Oregon Constitution and described in ORS 161.295 through 161.400 and OAR 309-032-0450 through 309-032-0515.

(55) "Registered Nurse" means an individual licensed and registered to practice nursing by the State of Oregon Board of Nursing in accordance with ORS Chapter 678 and 851.

(56) "Related" means spouse, domestic partner, natural parent, child sibling, adopted child, adopted parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew or first cousin.

(57) "Relative" means any person identified as family members.

(58) "Resident" means any person age 18 or older who receives room, board, care, and services in an Adult Foster Home.

(59) "Resident Manager" means an employee of the provider who is approved by the Department to live in the Adult Foster Home and is responsible for the care and services of residents on a day-to-day basis.

(60) "Residential Care" means the provision of room, board, and services that assist the resident in activities of daily living, such as assistance with bathing, dressing, grooming, eating, medication management, money management or recreation. Residential care includes 24 hour supervision; being aware of the residents' general whereabouts; monitoring the activities of the resident while on the premises of the Adult Foster Home to ensure their health, safety, and welfare; providing social and recreational activities; and assistance with money management as requested.

(61) "Residents' Bill of Rights" means residents of the Adult Foster Home have the following rights as defined in ORS 443.739. Each resident has a right to:

(a) Be treated as an adult, with respect and dignity;

(b) Be informed of all resident rights and all house rules;

(c) Be encouraged and assisted to exercise legal rights, including the right to vote;

(d) Be informed of the resident's medical condition and the right to consent to or refuse treatment;

(e) Receive appropriate care and services, and prompt medical care as needed;

(f) A safe and secure environment;

(g) Be free from mental and physical abuse;

(h) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner;

(i) Complete privacy when receiving treatment or personal care;

(j) Associate and communicate privately with any person the resident chooses;

(k) Send and receive personal mail unopened;

(l) Participate in activities of social, religious and community groups;

(m) Have medical and personal information kept confidential;

(n) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space;

(o) Manage the resident's own money and financial affairs unless legally restricted;

(p) Be free from financial exploitation. The provider must not charge or ask for application fees or nonrefundable deposits and must not solicit, accept or receive money or property from a resident other than the amount agreed to for services;

(q) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home;

(r) Not to be transferred or moved out of the adult foster home without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge a resident only for medical reasons including a medical emergency described in ORS 443.738(11)(a), or for the welfare of the resident or other residents, or for nonpayment;

(s) Be free of discrimination in regard to race, color, national origin, sexual orientation, disability, sex or religion;

(t) Make suggestions and complaints without fear of retaliation.

(62) "Respite Care" means the provision of room, board, care, and services in an Adult Foster Home for a period of up to 14 days. Respite care residents will be counted in the total licensed capacity of the home. Respite care is not crisis respite care.

(63) "Restraints" means any physical hold, device, or chemical substance, which restricts, or is meant to restrict, the movement or normal functioning of a resident.

(64) "Room and Board" means the provision of meals, a place to sleep, laundry and housekeeping.

(65) "Seclusion" means the involuntary confinement of an individual to a room or area where the person is physically prevented from leaving.

(66) "Self-Administration of Medication" means the act of a resident placing a medication in or on their own body. The resident identifies the medication and the times and manners of administration, and placed the medication internally or externally on their own body without assistance.

(67) "Self Preservation" in relation to fire and life safety means the ability of residents to respond to an alarm without additional cues and be able to reach a point of safety without assistance.

(68) "Services" means those activities which are intended to help the residents develop appropriate skills to increase or maintain their level of functioning and independence. Services include coordination and consultation with other service providers or entities to assure residents access to necessary medical care, treatment, and/or services identified in the resident's personal care plan.

(69) "Substitute Caregiver" means any person meeting the qualifications of a caregiver who provides care and services in an Adult Foster Home under the jurisdiction of the Department in the absence of the provider or resident manager. A resident may not be a substitute caregiver.

(70) "Unusual Incident" means those incidents involving acts of physical aggression, serious illnesses or accidents, any injury or illness of a resident requiring a non-routine visit to a health care practitioner, suicide attempts, death of a resident, a fire requiring the services of a fire Department, or any incident requiring an abuse investigation.

(71) "Variance" means an exception from a regulation or provision of these rules, granted in writing by the Department, upon written application from the provider.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0005, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 6-2007(Temp), f. & cert. ef. 5-25-07 thru 11-21-07; MHS 13-2007, f. & cert. ef. 8-31-07

309-040-0310
License Required

(1) License Required. In accordance with ORS 443.725 every provider of Adult Foster Care will be licensed with the Department of Human Services before opening or operating an Adult Foster Care Home for adult residents.

(a) A provider will live in the home that is to be licensed or hire a resident manager to live in the home.

(b) There will be a provider, resident manager or substitute caregiver on duty 24 hours per day in an Adult Foster Home under the jurisdiction of the Department of Services.

(2) Placement. No Adult Foster Home will accept placement of a person without first being licensed by the Department.

(3) Unlicensed Adult Foster Home. No individual will be placed in an Adult Foster Home that is not licensed.

(4) Criminal History Check Requirements. Providers, resident managers, substitute caregivers, volunteers and occupants over the age of 16, excluding residents, will have documentation of an approved criminal history/background check in accordance with ORS 181.537, 443.735 and OAR 407-007-0200 through 407-007-0380.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0010, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0315
License Application and Fees

(1) Application. A completed, written application will be submitted by the applicant on forms supplied by the Office of Mental Health and Addiction Services (OMHAS). The application is not complete until all information requested by the Department and on the forms supplied by OMHAS is submitted to the Department. Incomplete applications are void 60 days after initial receipt of by Office of Mental Health and Addiction Services (OMHAS).

(2) Additional Homes. A separate application is required for each location operated as an Adult Foster Home.

(3) Contents of Application. The application will include:

(a) The maximum resident capacity requested and will include family members needing care, persons who receive respite care, persons who receive day care and/or persons who receive room and board;

(b) A written statement from a Licensed Medical Practitioner regarding the mental and physical ability of the applicant to provide care to residents and to operate the Adult Foster Home. If the applicant will employ a resident manager, the applicant will provide a written statement from a physician or a Licensed Medical Practitioner regarding the mental and physical ability of the resident manager to operate the Adult Foster Home and to provide care to residents;

(c) A completed financial information form provided by OMHAS. The applicant will demonstrate to OMHAS their financial ability and the resources necessary to operate the Adult Foster Home. Financial ability will include but is not limited to, providing OMHAS with a list of unsatisfied judgments, pending litigation and unpaid taxes and notifying OMHAS regarding whether the applicant is in bankruptcy. If the applicant is unable to demonstrate the financial ability and resources required, OMHAS may require the applicant to furnish a financial guarantee as a condition of initial licensure in accordance with ORS 443.735(e) and 443.745;

(d) A completed Facility Provider Enrollment Application;

(e) A signed letter of support from the Local Mental Health Authority or designee for the applicant to be licensed to operate the Adult Foster Home;

(f) A copy of the documentation of Criminal History Check approval in accordance with OAR 407-007-0200 through 407-007-0380 for the provider(s), the resident manager, caregiver(s), volunteers and other occupants over the age of 16, excluding residents, and other persons as defined in ORS 443.735(5)(a)(b), (6)(a)(b)(c);

(g) A floor plan of the Adult Foster Home showing the location and size of rooms, exits, secondary emergency egress, smoke detectors and fire extinguishers and evidence of compliance with facility safety requirements as described in OAR 309-040-0370(1) through (13);

(h) A completed Adult Foster Home Self-Inspection Guide; and

(i) Each application will be accompanied by a fee of $20 per bed requested for license. This fee is waived for county-operated facilities.

(4) Review of Application. OMHAS will determine compliance with these rules based on receipt of the completed application material and fees, a review of information submitted, an investigation of information submitted, an inspection of the Adult Foster Home and interviews with the provider determined by OMHAS and other persons as identified by OMHAS.

(5) Withdrawal of Application. The applicant may withdraw the application at any time during the application process by notifying the Department in writing.

(6) Revocation, Surrender, Non-Renewal, or Denial of Application. An applicant whose license has been revoked or voluntarily surrendered, following a receipt of Notice of Intent to Revoke or Notice of Intent of Non-Renewal from the Department, or whose application has been denied by the Department for reasons relating to but not limited to, criminal convictions, civil proceedings against the applicant, or substantiated allegations of abuse by the applicant will not be permitted to submit an application for one year from the date that the revocation, surrender or denial is made final. A longer period may be specified in the order revoking or denying the license.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0015, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0320
Classification of Adult Foster Homes

The Office of Mental Health and Addiction Services (OMHAS) licenses Level 1 Adult Foster Homes. Level 1 Adult Foster Homes provide care and services to individuals with severe and persistent mental illness, who may also have limited medical conditions.

(1) Level One. A Level 1 Adult Foster Home license may be issued by the Department based upon a determination that a facility is in substantial compliance with these rules and a review of the qualifications of the provider and the resident manager, if there is one, and compliance with the following requirements.

(2) Requirement for Issuance of License. A Level 1 Adult Foster Home license will be issued by the Office of Mental Health and Addiction Services (OMHAS) if the applicant or resident manager completes the training requirements outlined in OAR 309-040-0335, and the home and provider are in compliance with OAR 309-040-0300 through 309-040-0455.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0011, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0325
Capacity

(1) Number of Residents. The number of residents permitted to reside in an Adult Foster Home will be determined by the ability of the caregiver to meet the care needs of the residents, the fire safety standards, and compliance with the physical structure standards of these rules. Determination of maximum licensed capacity will include consideration of total household composition including children.

(a) Sleeping arrangements for children in care will be safe and appropriate, based on the child's age, gender, special needs, behavior, and history of abuse and neglect.

(b) Each child in care will have a safe and adequate bed in which to sleep.

(2) Limiting Capacity. The following limits apply:

(a) The number of residents will be limited to five;

(b) Respite care persons are included in the licensed capacity of five;

(c) Day care persons are included in the licensed capacity of five;

(d) Adult family members of the provider or resident manager who need care are included in the licensed capacity of five; and,

(e) Child family members of the provider or resident manager who need care may be included in the licensed capacity of five.

(3) Ability to Provide Care. If the number of persons who receive care exceeds the ability of the provider to meet the care, health, life, and safety needs of the residents, OMHAS may reduce the licensed capacity of the adult foster home.

(4) Conditions on Capacity. OMHAS may place conditions, restrictions, or limitations on the AFH license as necessary to maintain the health, life, and safety of the residents.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0012, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0330
Zoning for Adult Foster Homes

An Adult Foster Home is a residential use of property for zoning purposes. Under ORS 197.665, an Adult Foster Home is a permitted use in any residential zone, including a residential zone, which allows a single family dwelling, and in any commercial zone which allows a single family dwelling. No city or county may impose any zoning requirement on the establishment and maintenance of an Adult Foster

Home in these zones that is more restrictive than that imposed on a single-family dwelling in the same zone.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0100, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0335
Training Requirements for Providers, Resident Managers, and Substitute Caregivers

(1) Training Requirements and Compliance. All providers, resident managers, and substitute caregivers will satisfactorily meet all educational requirements established by the Department of Human Services. No person may provide care to any resident prior to acquiring education or supervised training designed to impart the basic knowledge and skills necessary to maintain the health, safety and welfare of the resident. Required course work and necessary skills may include, but are not limited to: physical caregiving; screening for care and service needs; appropriate behavior towards residents with physical, cognitive and emotional disabilities; emergency procedures; medication management; personal care products; food preparation; home environment and safety procedures; residents' rights; issues related to architectural accessibility; and, mandatory abuse reporting.

(2) Ability to Communicate. The provider, resident manager, and substitutive caregivers will be able to understand and communicate in oral and written English in accordance with ORS 443.730.

(3) Testing Requirements. Training for all providers, resident managers and substitute caregivers will be in compliance with ORS 443.738. The provider will satisfactorily pass any testing requirements established by the Department before being licensed or becoming a resident manager or substitute caregiver. The test will be completed by the caregiver without the help of any other person. The provider, resident manager and substitute caregiver will have the ability to, but will not be limited to, understanding and responding appropriately to emergency situations, changes in medical conditions, physicians' orders and professional instructions, nutritional needs, residents' preferences and conflicts.

(4) Exceptions to Training Requirements. The Department may make exceptions to the training requirements for persons who are appropriately licensed medical care professional in Oregon or who possess sufficient education, training, or experience to warrant an exception. The Department will not make any exceptions to the testing requirements.

(5) Unexpected and Urgent Staffing Need. In accordance with ORS 443.738, the Department may permit a person who has not completed the training or passed the required test to act as a resident manager until the training and testing are completed, or for 60 days, whichever is shorter, if the Department determines that an unexpected and urgent staffing need exists. The licensed provider will notify the Office of Mental Health and Addiction Services of the situation and demonstrate that the provider is unable to find a qualified resident manager, that the person has met the requirements for a substitute caregiver for the Adult Foster Home, and that the provider will provide adequate supervision.

(6) Documentation of Current Training and Testing. The provider or resident manager will maintain current documentation of the training and testing of substitute caregivers including but not limited to:

(a) Documentation of criminal history check in compliance with OAR 410-007-0200 through 410-007-0380.

(b) Documentation that substitute caregiver has successfully completed the training required by the Office of Mental Health and Addiction Services.

(c) Documentation that provider has trained the caregiver to meet the routine and emergency needs of the residents.

(d) Documentation that provider has oriented the caregiver to the residents in the Adult Foster Home, their care needs and skills training, personal care plan, and the physical characteristics of the Adult Foster Home.

(7) Annual Training Hours. The Department will require a minimum of twelve hours of training annually directly related to the care and services for persons with mental illness. The training for the provider, resident manager, and substitute caregiver of an Adult Foster Home will be documented in the provider, resident manager, and substitute caregiver's training records. Such training will be in addition to any orientation, which is attended by applicants prior to licensing and will include, but is not limited to:

(a) Understanding and Recognizing Severe and Persistent Mental Illness

(b) Mandatory Abuse Reporting

(c) Medication Management, Dispensing, and Documentation

(d) Incident Report Writing

(e) Resident Rights

(f) Adult Foster Home Emergency Planning

(g) Fire Safety

(h) Complaints and Grievances

(i) Cardiopulmonary Resuscitation (CPR) and First Aid

(8) Additional Training Requirements. The Department may require the provider, resident manager or substitute caregiver to obtain additional training, whether or not the twelve hour annual training requirement has already been met as specified by the Department.

(9) Training for Delegated and/or Assigned Nursing Care Services. Providers, resident managers or substitute caregivers who perform delegated and/or assigned nursing care services as part of the Personal Care Plan will receive training and appropriate monitoring from a registered nurse on performance and delivery of those services.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0030, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0340
Issuance of a License

(1) Issuance of a License. Applicants will be in substantial compliance with these Administrative Rules and Oregon Revised Statutes (ORS) 443.705 through 443.825 before a license is issued. If cited deficiencies are not corrected within time frames specified by the Department, the application will be denied. The Department will issue a license to an applicant that is found to be in substantial compliance with these rules. The license will state, but is not limited to, the name of the applicant, name of the Adult Foster Home, address of premises to which license applies, the maximum number of residents, resident manager (if applicable), conditions (if applicable), license number, payment received, effective date and expiration date, and the signature of the Assistant Administrator of the Office of Mental Health and Addiction Services (OMHAS). The license will be visibly posted in the Adult Foster Home and available for inspection at all times.

(2) Conditions on a License. The Department may attach conditions to the license, which limit, restrict, or specify other criteria for operation of the Adult Foster Home. Conditions to a license may include, but are not limited to, care of a specifically identified individual. The conditions will be posted with the license in the Adult Foster Home and be available for inspection at all times.

(3) Reporting Changes. Each licensee will report promptly to OMHAS any significant changes to information supplied in the application or subsequent correspondence. Such changes include, but are not limited to, changes in the Adult Foster Home name, owner entity, resident manager, telephone number, and/or mailing address. Such changes include, but are not limited to, changes in staffing when such changes are significant or impact the health, safety, or well being of residents.

(4) Change of Ownership of an Adult Foster Home. When an Adult Foster Home is sold, the prospective new owner will apply for a license in accordance with OAR 309-040-0315 License Application and Fees if the new owner intends to operate an Adult Foster Home to be licensed by OMHAS.

(5) Transfer of License. An Adult Foster Home license is not transferable or applicable to any location or persons other than those specified on the license.

(6) Effective Date of a License. A license is valid for one year from the effective date on the license unless sooner revoked or suspended.

(7) Substantial Compliance Requirements. Applicants will be in substantial compliance with these Administrative Rules before a license is issued. If cited deficiencies are not corrected within the time frames specified by the Department, the license will be denied.

(8) Issuing a License in Compliance. The Department will not issue an initial license unless:

(a) The applicant and the Adult Foster Home are in compliance with ORS 443.705 to 443.825 and the rules of the Department;

(b) The Department has completed an inspection of the Adult Foster Home. If cited deficiencies are not corrected within the time frames specified by the Department, the application will be denied;

(c) The Department has received an approved criminal history records check on the applicant, resident manager, substitute caregiver, and any occupant (other than a resident), 16 years of age or older or is identified in ORS 443.735(5)(a)(b), (6)(a)(b)(c) and who will be residing in or employed by the Adult Foster Home, as identified in OAR 407-007-0200 through 407-007-0380, and any other rules established by the Department.

(9) Financial Ability and Resources. The applicant will demonstrate to the Department the financial ability and resources necessary to operate the Adult Foster Home. The demonstration of financial ability will include, but need not be limited to, providing the Department with a list of any unsatisfied judgments, pending litigation and unpaid taxes and notifying the Department regarding whether the applicant is in bankruptcy. If the applicant is unable to demonstrate the financial ability and resources required by this paragraph, the Department may require the applicant to furnish a financial guarantee as a condition of initial licensure.

(10) Resident Manager Changes. If a resident manager changes during the period of the license, the provider will notify OMHAS immediately and identify a plan for providing care to the residents. The provider will submit a completed resident manager application on forms supplied by OMHAS that include, a copy of the documentation of criminal history background check and approval in accordance with OAR 407-007-0200 through 407-007-0380, a physicians statement and payment of a $10.00 fee. If the resident manager is to change during the license renewal process the $10.00 is not applicable.

(11) Revised License. Upon receipt of the completed resident manager application and approval by OMHAS a revised license will be issued by OMHAS in accordance with ORS 443.738(1) through (4).

(12) 60-Day Provisional License. Notwithstanding any other provision of ORS 443.735 or 443.725 or 443.738, the Department may issue a 60-day provisional license to a qualified person if the Department determines that an emergency situation exists after being notified that the licensed provider of an Adult Foster Home is no longer overseeing operation of the Adult Foster Home.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99); Renumbered from 309-040-0020, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0345
Renewal

(1) Renewal Application and Fee. The provider will submit a completed OMHAS renewal application and the required fee at least 165 days prior to the expiration date of the license. If the renewal application is not received from OMHAS within the time period described, the provider must request the application from OMHAS or the County Mental Health partner. If the completed renewal application and fee are not submitted prior to the expiration date, the Adult Foster Home will be treated as an unlicensed facility, subject to civil penalties.

(2) Exceptions for Renewal Application. The renewal application will include the same information and fee as required for a new application, except that a physician's statement and financial information form are not required if OMHAS can reasonably assume this information has not changed.

(3) Additional Requirements for Renewal Application. OMHAS will require the applicant to submit a current (within six months) physician's statement and a current (within six months) criminal history check if investigation by OMHAS for license renewal indicates that it is necessary.

(4) Information Investigation and Site Inspection. OMHAS will investigate any information in the renewal application and will conduct an inspection of the Adult Foster Home.

(5) Inspection Report. The provider will be given a formal written report from the inspection citing any deficiencies and a time frame for correction that does not exceed 30 days from the date of the inspection report unless otherwise noted in the inspection report.

(6) Correction of Deficiencies. OMHAS will require the Adult Foster Home provider to correct deficiencies prior to issuing a renewed license. If cited deficiencies are not corrected within the time frame specified by OMHAS, the renewal application will be denied and administrative sanctions will be imposed.

(7) Requirements for License Renewal. OMHAS will not renew a license unless:

(a) The applicant and the Adult Foster Home are in compliance with ORS 443.705 to 443.825 and the rules of OMHAS;

(b) OMHAS has completed an inspection of the Adult Foster Home;

(c) OMHAS has completed a criminal records check as required by ORS 181.536 through 181.537, 443.735 and OAR 407-007-0200 through 407-007-0380 on the applicant and any occupant, other than a resident, 16 years of age or older or is identified in ORS 443.735(5)(a)(b), (6)(a)(b)(c) and who will be residing in or employed by or otherwise acting as a provider, resident manager, substitute caregiver or volunteer for the Adult Foster Home provider.

(8) National Criminal Record Check. The provider, resident manager, substitute caregiver or volunteer or person residing in the Adult Foster Home may continue to work or reside in the home pending the national criminal records check provided that the Oregon criminal record check was clear and no convictions were self disclosed in accordance with OAR 407-007-0200 through 407-007-0380.

(9) Criminal Record Check. A criminal records check will be completed for the applicant and any occupant, other than a resident, 16 years of age or older who will be residing in or employed by or otherwise acting as a provider, resident manager, substitute caregiver or volunteer for the Adult Foster Home provider if OMHAS believes there is reason to justify a new criminal history check in accordance with OAR 407-007-0220(2)(a)–(d) Criminal History Check Required.

(10) Burden of Proof — Less than 24 Months. An Adult Foster Home provider seeking initial licensing or in operation for less than 24 months, carries the burden of proof to establish compliance with ORS 443.705 to 443.825 and OMHAS rules.

(11) Burden of Proof — More than 24 Months. The burden of proof will be upon OMHAS to establish compliance with ORS 443.705 to 443.825 and OMHAS rules if an Adult Foster Home provider is seeking renewal of a license and has been in continuous operation for more than 24 months.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0025, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0350
Variance

(1) A provider or applicant may apply to the Department for a variance from a provision of these rules. The provider must justify to the Department that such a variance does not jeopardize the health, life, or safety of the residents, and the variance would not violate or compromise applicable ORS.

(2) No variance will be granted from a regulation or provision of these rules pertaining to the license capacity of the Adult Foster Home, inspections of the Adult Foster Home, civil, legal and human rights, and inspection of the public files. No variance related to fire and life safety will be granted by the Department without prior consultation with the local fire Department or its designee.

(3) A provider or applicant may apply to the Department for a variance specific to each individual resident under ORS 443.725, subject to the following requirements:

(a) The variance is effective only for the specific resident who has been assessed and meets the safety requirements prescribed by the Department. This assessment shall become part of the resident's PCP;

(b) A variance allowing a specific resident to be in the Adult Foster Home alone shall not exceed 4 hours in a 24 hour period;

(c) No variance allows a provider to leave a resident alone in the Adult Foster Home between the hours of 11:00 pm to 6:00 am; and

(b) 24 hour per day care shall continue for any resident that does not qualify to be in the Adult Foster Home alone.

(4) Variances will be granted or denied in writing. All variances granted will be reviewed with each license renewal under OAR 309-040-0345. A variance granted to one Adult Foster Home provider, or

a variance granted regarding a specific resident, does not constitute a precedent for any other Adult Foster Home, provider or resident.

(5) The AFH provider or applicant may appeal the denial of a variance request by submitting a request for reconsideration in writing to the Department. The Department will make a decision on the appeal within 30 days of receipt of the appeal. The decision of the Department will be final.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0035, MHD 3-2005, f. & cert. ef. 4-1-05; MHS 2-2007(Temp), f. & cert. ef. 5-4-07 thru 10-31-07; MHS 12-2007, f. & cert. ef. 8-31-07

309-040-0355
Contracts

(1) Public Assistance Individuals. Providers who care for public assistance individuals must enter into a contract with the Department and follow Department rules governing reimbursement for services and refunds.

(2) Private Pay Individuals. Providers who care for private paying residents must enter into a signed contract with the resident or person paying for care. This contract will include, but is not limited to, a Personal Care Plan (PCP), a schedule of rates, conditions under which the rates can be changed, and the Adult Foster Home's policy on refunds at the time of hospitalization, death, discharge, or voluntary move.

(3) Notification of Increases, Additions, and Other Modifications of Rates. Thirty days prior written notification of increases, additions, and other modifications of the rates to be charged will be given by the provider to private residents or persons paying for care unless the change is due to a medical emergency resulting in a greater level of care, in which case the notice will be given within ten days of the change.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0040, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0360
Qualifications for Adult Foster Home Providers, Resident Managers and Other Caregivers

(1) Qualifications for a Provider. An Adult Foster Home provider must meet the following qualifications:

(a) Be at least 21 years of age;

(b) Live in the Adult Foster Home to be licensed, unless an approved resident manager lives in the Adult Foster Home;

(c) Provide evidence satisfactory to the Department regarding experience, training, knowledge, interest, and concern in providing care to persons with severe and persistent mental illness. Such evidence may include, but is not limited to:

(A) Certified nurse's aide training;

(B) Nursing home, hospital or institutional work experience;

(C) Licensed practical nurse or registered nurse training and experience;

(D) Training approved by the Department;

(E) Experience in caring for persons with severe and persistent mental illness at home; and

(F) Home management skills.

(d) Possess the physical health and mental health determined necessary by the Department to provide 24-hour care for adults who are mentally ill. Applicants must have a statement from a physician, on a form provided by the Department, that they are physically and mentally capable of providing care;

(e) Undergo a criminal history check in accordance with OAR 407-007-0200 through 407-007-0380 and be deemed eligible for licensure by the Department. The Department will evaluate and verify information regarding criminal history;

(f) Provide evidence of sufficient financial resources to operate an Adult Foster Home for at least two months, unless the application is for renewal of an Adult Foster Home that is already in operation. A credit reference check may be required;

(g) Be literate and capable of understanding written and oral orders and communicating with residents, physician, case manager, and appropriate others; and be able to respond appropriately to emergency situations at all times;

(h) If transporting residents by motorized conveyance, must have a current driver's license in compliance with Department of Motor Vehicles laws and vehicle insurance as required by the State of Oregon.

(2) Qualifications for a Resident Manager. The resident manager will meet the provider qualifications listed in subsection (1)(a) through (h) of this rule. A resident manager applicant may work in the home pending outcome of the national criminal history check, if the Oregon criminal history check was clear and no convictions were self-disclosed on the criminal record authorization.

(3) Qualifications for a Substitute Caregiver. Substitute caregivers left in charge of residents for any period of time will have access to resident records and meet the following qualifications:

(a) Be at least 18 years of age;

(b) Be subject to a Criminal History Check. A substitute caregiver may work in the home pending outcome of the national criminal history check providing the Oregon criminal history check was clear and no convictions were self-disclosed on the criminal record authorization;

(c) Be able to communicate orally and in writing with residents, physicians, case managers, and appropriate others;

(d) Know fire safety and emergency procedures;

(e) Have a clear understanding of job responsibilities, have knowledge of Personal Care Plans and be able to provide the care specified for each resident's needs;

(f) Be able to meet the requirements of a resident manager when left in charge of an Adult Foster Home for 30 days or longer;

(g) Not be a resident; and

(h) If transporting residents by motorized conveyance, must have a current driver's license in compliance with Department of Motor Vehicles laws and vehicle insurance as required by the State of Oregon.

(4) Providers Responsibility for Standards. Providers will not hire or continue to employ a resident manager or substitute caregiver that does not meet the standards stated in this rule.

(5) Providers Responsibility for Supervision and Training. A provider is responsible for the supervision and training of resident managers and substitute caregivers and their general conduct when acting within the scope of their employment and/or duties.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0045, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0365
Facility Standards

In order to qualify for or maintain a license, an Adult Foster Home will meet the following provisions.

(1) Compliance with Building and Fire Code. Demonstrate compliance with **Oregon Structural Specialty Code** (OSSC) and **Oregon Fire Code**: and

(a) Each Adult Foster Home will maintain up-to-date documentation verifying they meet applicable local business license, zoning, and building and housing codes, and state and local fire and safety regulations. It is the duty of the provider to check with local government to be sure all applicable local codes have been met;

(b) Each Adult Foster Home established on or after October 1, 2004 will meet all applicable State building, mechanical, and housing codes for fire and life safety. The Adult Foster Home will be inspected for fire safety by an inspector designated by the Department using the recommended standards established by the State Fire Marshal for facilities housing one to five persons. Refer to Appendix I of the Oregon Fire Code, the Oregon Residential Specialty Code, and the Oregon Structural Specialty Code. When deemed necessary by the Department, a request for fire inspection will be made to the State Fire Marshal.

(c) The building and furnishings will be clean and in good repair and grounds will be maintained. Walls, ceilings, and floors will be of such character to permit frequent washing, cleaning, or painting. There will be no accumulation of garbage, debris, rubbish or offensive odors;

(d) Stairways will be provided with handrails. A functioning light will be provided in each room, stairway, and exit way; incandescent light bulbs will be protected with appropriate covers. Yard and exterior steps will be accessible to residents;

(e) The heating system will be in working order. Areas of the Adult Foster Home used by residents will be maintained at no less than 68 degrees Fahrenheit during the day and 60 degrees Fahrenheit during sleeping hours. During times of extreme summer heat, the provider will make a reasonable effort to make the residents comfortable using available ventilation or fans;

(f) There will be at least 150 square feet of common space, and sufficient comfortable furniture in the Adult Foster Home to accommodate the recreational and socialization needs of the occupants at one time. Common space will not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit. Additional space will be required if wheelchairs are to be accommodated;

(g) Pools and hot tubs will be equipped with sufficient safety barriers or devices to prevent accidental injury in accordance with Section R116 of the Oregon Residential Specialty Code.

(2) Accessibility for Persons with Disabilities. Any accessibility improvements made to accommodate an identified resident will be in accordance with the specific needs of the resident and will comply with Chapter 11 of the building code.

(3) Outdoor Areas. An accessible outdoor area is required and will be made available to residents. A portion of the outdoor area will be covered and have an all weather surface, such as a patio or deck.

(4) Storage Areas. Storage for a reasonable amount of resident personal belongings beyond that of the resident sleeping room will be made available.

(a) All yard maintenance equipment will be maintained in a locked storage if such equipment poses a safety threat.

(b) A locked storage area for resident medications separate from food, laundry and toxic or hazardous materials will be made accessible to all caregivers. For residents who are self-medicating a secured locked box will be made available to assure the safety of all occupants of the home.

(c) A locked storage area separate from food and medications will be designated when there are toxic or hazardous materials on the premises.

(5) Bathrooms. All equipment will be clean and in good repair and will provide individual privacy and have: a finished interior; a mirror; an operable window or other means of ventilation; and a window covering.

(a) Will have tubs or showers, toilets and sinks, and hot and cold water. A sink will be located near each toilet. A toilet and sink will be provided on each floor where rooms of non-ambulatory residents or residents with limited mobility are located. There will be at least one toilet, one sink, and one tub or shower for each six household occupants, including the provider and family;

(b) Will have hot and cold water in sufficient supply to meet the needs of residents for personal hygiene. Hot water temperature sources for bathing areas will not exceed 120 degrees Fahrenheit;

(c) Will have shower enclosures with nonporous surfaces; glass shower doors will be tempered safety glass. Shower curtains will be clean and in good condition. Non-slip floor surfaces will be provided in tubs and showers;

(d) Will have grab bars for toilets, tubs, and/or showers for resident's safety as required by resident's disabilities;

(e) No person will walk through another person's bedroom to get to a bathroom and will have barrier-free access to toilet and bathing facilities with appropriate fixtures.

(f) If there are non-ambulatory residents; alternative arrangements for non-ambulatory residents must be appropriate to resident needs for maintaining good personal hygiene.

(g) Residents will have appropriate racks or hooks for drying bath linens.

(6) Bedrooms. All furniture and furnishings will be clean and in good repair. Bedrooms for all household occupants will have been constructed as a bedroom when the home was built or remodeled under permit; be finished, with walls or partitions of standard construction which go from floor to ceiling, and a door which opens directly to a hallway or common use room without passage through another bedroom or common bathroom; be adequately ventilated, heated and lighted with at least one operable window which meets fire egress regulations. (*See* Section R310 Emergency Escape and Rescue Openings in the **Oregon Residential Specialty Code**.) All resident sleeping rooms will include a minimum of 70 square feet of usable floor space for each resident or 120 square feet for two residents and have no more than two persons per room and allow for a minimum of three feet between beds;

(a) Providers, resident managers or family members will not sleep in areas designated as living areas, nor share bedrooms with residents;

(b) In determining maximum capacity, consideration will be given to whether children over the age of five have a bedroom separate from their parents.

(c) Bedrooms will be on ground level for residents who are non-ambulatory or have impaired mobility;

(d) Resident bedrooms will be in close enough proximity to alert provider to night time needs or emergencies, or be equipped with a call bell or intercom.

(7) Housing Codes. Each Adult Foster Home established on or after October 1, 2004 will meet all applicable State building, residential, fire, mechanical, and housing codes for fire and life safety. The Adult Foster Home will be inspected for fire safety by an inspector designated by the Department using the recommended standards established by the State Fire Marshal for facilities housing one to five persons. Refer to Appendix I of the **Oregon Fire Code**, the **Oregon Residential Specialty Code**, and the **Oregon Structural Specialty Code**. When deemed necessary by the Department, a request for fire inspection will be made to the State Fire Marshal.

(8) Special hazards.

(a) Flammable and combustible liquids and hazardous materials will be safely and properly stored in original, properly labeled containers, or safety containers, and secured to prevent tampering by residents and vandals. Firearms on the premises of an AFH must be stored in a locked cabinet. The firearms cabinet must be located in an area of the home that is not readily accessible to clients and all ammunition must be stored in a separate, locked location;

(b) Smoking regulations will be adopted to allow smoking only in designated areas. Smoking will be prohibited in sleeping rooms and upon upholstered crevasse furniture. Ashtrays of noncombustible material and safe design will be provided in areas where smoking is permitted;

(c) Cleaning supplies, poisons and insecticides will be properly stored in original, properly labeled containers in a safe area away from food, preparation and storage, dining areas, and medications.

(9) Common Use Rooms. All furniture and furnishings will be clean and in good repair. There will be at least 150 square feet of common space, and sufficient comfortable furniture in the Adult Foster Home to accommodate the recreational and socialization needs of the occupants at one time. Common space will not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit. Additional space will be required if wheelchairs are to be accommodated;

(10) Laundry and Related Space. All equipment will be clean and in good repair. Laundry facilities will be separate from food preparation and other resident use areas.

(a) Locked storage area for chemicals that pose a safety threat to residents or family members;

(b) Sufficient, separate storage and handling space to ensure that clean laundry is not contaminated by soiled laundry;

(c) Outlets, venting and water hookups according to State Building Code requirements; and

(d) Washers will have a minimum rinse temperature of 140 degrees Fahrenheit.

(11) Kitchen. All equipment will be clean and in good repair. Dry storage, not subject to freezing, in cabinets or a separate pantry for a minimum of one week's supply of staple foods.

(a) Sufficient refrigeration space maintained at 45 degrees Fahrenheit or less and freezer space for a minimum of two days supply of perishable foods;

(b) A dishwasher with a minimum final rinse of 140 degrees Fahrenheit;

(c) Smooth, nonabsorbent and cleanable counters for food preparation and serving;

(d) Appropriate storage for dishes and cooking utensils designed to be free from potential contamination;

(e) Stove and oven equipment for cooking and baking needs;

(f) Storage for a mop and other cleaning tools and supplies used for food preparation, dining and adjacent areas. Such cleaning tools

will be maintained separately from those used to clean other parts of the home; and

(g) Dining Space where meals are served will be provided to seat all residents at the same seating.

(12) Details and Finishes:

(a) The building and furnishings will be clean and in good repair and grounds will be maintained. Walls, ceilings, and floors will be of such character to permit frequent washing, cleaning, or painting

(b) Doors. If locks are used on doors to resident sleeping rooms, they will be in good repair with an interactive lock to release with operation of the inside door handle and be master keyed from the corridor side. Exit doors will not include locks, which prevent evacuation except as permitted by Section 1008.1.8 of the building code. An exterior door alarm or other acceptable system may be provided for security purposes and alert the provider when resident(s) or others enter or exit the home.

(c) Handrails. Handrails will be secured on all stairways.

(13) Heating and Ventilation. The heating system will be in working order:

(a) Temperature Control. Areas of the Adult Foster Home used by residents will be maintained at no less than 68 degrees Fahrenheit during daytime hours and no less than 60 degrees Fahrenheit during sleeping hours. During times of extreme summer heat, the provider will make reasonable effort to make the residents comfortable using available ventilation or fans;

(b) Exhaust Systems. All toilets and shower rooms will be ventilated by a mechanical exhaust system or operable window.

(c) Fireplaces, Furnaces, Wood Stoves. Design and installation will meet standards of the Oregon Mechanical and Residential Specialty Code and will have annual inspections to assure no safety hazard exists.

(d) Water Temperature in resident areas, hot water temperatures will be maintained within a range of 110º to 120 degrees Fahrenheit. Hot water temperatures for washing machines and dishwashers will be at least 140 degrees Fahrenheit.

(14) Electrical. All electrical systems will meet the standards of the Oregon Electrical Specialty Code in effect on the date of installation, and all electrical devices will be properly wired and in good repair:

(a) When not fully grounded, GFI-type receptacles or circuit breakers as an acceptable alternative may protect circuits in resident areas.

(b) Circuit breakers or non-interchangeable circuit-breaker-type fuses in fuse boxes will be used to protect all electrical circuits.

(c) A sufficient supply of electrical outlets will be provided to meet resident and staff needs without the use of extension cords or outlet expander devices.

(d) A functioning light will be provided in each room, stairway, and exit way. Lighting Fixtures will be provided in each resident bedroom and bathroom, with a light switch near the entry door, and in other areas as required to meet task illumination needs.

(e) Incandescent light bulbs will be protected with appropriate covers.

(15) Plumbing. All plumbing will meet the Oregon Plumbing Specialty Code in effect on the date of installation, and all plumbing fixtures will be properly installed and in good repair.

(16) Pool, Hot Tubs and Ponds. Pools, hot tubs, and ponds will be equipped with sufficient safety barriers or devices to prevent accidental injury in accordance with Section R116 of the Oregon Residential Specialty Code.

(17) Telephones:

(a) A telephone will be available and accessible for residents' use for incoming and outgoing calls in the Adult Foster Home;

(b) Emergency telephone numbers for the local CMHP, Police, Fire, Medical, Poison Control, Provider and other emergencies will be posted by the residents telephone. The posting will include the name, address and telephone number of the Adult Foster Home, telephone numbers for making complaints or a report of alleged abuse to the local CMHP, OMHAS, the Office of Investigations and Training, and the Oregon Advocacy Center.

(c) Limitations on the use of the telephone by residents are to be specified in the written house rules. Individual restrictions must be specified in the individual residents PCP. In all cases, a telephone will be accessible to residents for outgoing calls (emergencies) 24 hours a day;

(d) AFH telephone numbers must be listed in the local telephone directory.

(e) The home may establish reasonable rules governing telephone use to ensure equal access by all residents. Each resident or guardian (as applicable) will be responsible for payment of long distance phone bills where calls were initiated by the resident, unless otherwise mutually agreed arrangements have been made.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Sections (8)-(10) renumbered to 309-040-0052; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0050, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0370
Safety

(1) Training on Safety Procedures. All staff will be trained in staff safety procedures prior to beginning their first regular shift. All residents will be trained in resident safety procedures as soon as possible during their first 72 hours of residency.

(2) Emergency Procedure.

(a) An emergency evacuation procedure will be developed, posted, and rehearsed with occupants. A record will be maintained of evacuation drills. Drills will be scheduled at different times of the day and on different days of the week with different locations designated as the origin of the fire for drill purposes.

(A) Drills will be held at least once every 30 days.

(B) One drill practice will be held at least once every 90 days during resident's nighttime sleeping hours. Fire drill records will be maintained for three years and will include date, time for full evacuation, safety equipment checked (to include fire extinguishers, smoke detectors, secondary egress points, flashlights, and furnace filters), comments on the drill results, and names of residents requiring assistance for evacuation;

(b) The Personal Care Plan must document that, within 24 hours of arrival, each new resident has received an orientation to basic safety and has been shown how to respond to a fire alarm, and how to exit from the Adult Foster Home in an emergency;

(c) The provider will demonstrate the ability to evacuate all residents from the Adult Foster Home within three minutes. If there are problems in demonstrating this evacuation time, the licensing authority may apply conditions to the license which include, but may not be limited to, reduction of residents under care, additional staffing, increased fire protection, or revocation of the license;

(d) The provider will provide to OMHAS, maintain as current, and post a floor plan on each floor containing room sizes, location of each resident's bed, fire exits, resident manager or provider's sleeping room, smoke detectors, fire extinguishers and escape routes. A copy of this drawing will be submitted with the application and updated to reflect any change;

(e) There will be at least one plug-in rechargeable flashlight available for emergency lighting in a readily accessible area on each floor including basement.

(3) Disaster Plan. A written disaster plan will be developed to cover such emergencies and disasters as fires, explosions, missing persons, accidents, earthquakes and floods. The plan will be posted by the phone and immediately available to the employees. The plan will specify temporary and long-range habitable shelter where staff and residents will go if the home becomes uninhabitable.

(4) Poisonous and Other Toxic Materials. Non-toxic cleaning supplies will be used whenever available. Poisonous and other toxic materials will be properly labeled and stored in locked areas distinct and apart from all food and medications.

(5) Evacuation Capability. Evacuation capability categories are based upon the ability of the residents and staff as a group to evacuate the home or relocate from a point of occupancy to a point of safety.

(a) Documentation of a resident's ability to safely evacuate from the Adult Foster Home will be maintained in the individual resident's personal care plan.

(b) Persons experiencing difficulty with evacuating in a timely manner will be provided assistance from staff and offered environmental and other accommodations, as practical. Under such circumstances,

the Adult Foster Home will consider increasing staff levels, changing staff assignments, offering to change the resident's room assignment, arranging for special equipment, and taking other actions that may assist the resident.

(c) Residents who still cannot evacuate the home safely in the allowable period of time (3 minutes) will be assisted with transferring to another program with an evacuation capability designation consistent with the individual's documented evacuation capability.

(d) Written evacuation records will be retained for at least three years. Records will include documentation, made at the time of the drill, specifying the date and time of the drill, the location designated as the origin of the fire for drill purposes, the names of all individuals and staff present, the amount of time required to evacuate, notes of any difficulties experienced, and the signature of the staff person conducting the drill.

(6) Unobstructed Egress. All stairways, halls, doorways, passageways, and exits from rooms and from the home will be unobstructed.

(7) Portable Firefighting Equipment. At least one 2A-10BC rated fire extinguisher will be in a visible and readily accessible location on each floor, including basements, and will be inspected at least once a year by a qualified worker that is well versed in fire extinguisher maintenance. All recharging and hydrostatic testing will be completed by a qualified agency properly trained and equipped for this purpose;

(8) Smoke Alarms. Approved smoke detector systems or smoke alarms will be installed according to Oregon Residential Specialty Code and Oregon Fire Code requirements. These alarms will be tested during each evacuation drill. The Adult Foster Home will provide approved signal devices for persons with disabilities who do not respond to the standard auditory alarms. All of these devices will be inspected and maintained in accordance with the requirements of the State Fire Marshal or local agency having jurisdiction. Ceiling placement of smoke alarms or detectors is recommended. Alarms will be equipped with a device that warns of low battery when battery operated. All smoke detectors and alarms are to be maintained in functional condition;

(9) Special hazards:

(a) Flammable and combustible liquids and hazardous materials will be safely and properly stored in original, properly labeled containers or safety containers, and secured to prevent tampering by residents and vandals. Firearms on the premises of an Adult Foster Home must be stored in a locked cabinet. The firearms cabinet must be located in an area of the home that is not readily accessible to clients and all ammunition must be stored in a separate, locked location;

(b) Smoking regulations will be adopted to allow smoking only in designated areas. Smoking will be prohibited in sleeping rooms and upon upholstered crevasse furniture. Ashtrays of noncombustible material and safe design will be provided in areas where smoking is permitted;

(c) Cleaning supplies, poisons and insecticides will be properly stored in original, properly labeled containers in a safe area away from food, preparation and storage, dining areas, and medications.

(10) Sprinkler Systems. Sprinkler systems, if used, will be installed in compliance with the Oregon Structural Specialty Code and Oregon Fire Code and maintained in accordance with rules adopted by the State Fire Marshal.

(11) First Aid Supplies. First aid supplies will be readily accessible to staff. All supplies will be properly labeled.

(12) Portable Heaters. Portable heaters are a recognized safety hazard and will not be used, except as approved by the State Fire Marshal, or authorized representative.

(13) Safety Program. A safety plan will be developed and implemented to identify and prevent the occurrence of hazards. Hazards may include, but are not limited to, dangerous substances, sharp objects, unprotected electrical outlets, use of extension cords or other special plug-in adapters, slippery floors or stairs, exposed heating devices, broken glass, inadequate water temperatures, overstuffed furniture in smoking areas, unsafe ashtrays and ash disposal, and other potential fire hazards.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0375
Sanitation

(1) Water Supply. The water supply in the home will meet the requirements of the current rules of the Department governing domestic water supplies.

(a) A municipal water supply will be utilized if available.

(b) When the home is not served by an approved municipal water system, and the home qualifies as a public water system according to OAR 333-061-0020(94), Department rules for public water systems, then the home will comply with the OAR chapter 333 rules of the Department pertaining to public water systems. These include requirements that the drinking water be tested for total coliform bacteria at least quarterly, and nitrate at least annually, and reported to the Department. For adverse test results, these rules require that repeat samples and corrective action be taken to assure compliance with water quality standards, that public notice be given whenever a violation of the water quality standards occurs, and that records of water testing be retained according to the Department requirements.

(2) Surfaces. All floors, walls, ceilings, windows, furniture, and equipment will be kept in good repair, clean, neat, and orderly.

(3) Plumbing Fixtures. Each bathtub, shower, lavatory, and toilet will be kept clean, in good repair and regularly sanitized.

(4) Disposal of Cleaning Waste Water. No kitchen sink will be used for the disposal of cleaning wastewater.

(5) Soiled Laundry. Soiled linens and clothing will be stored in an area or container separate from kitchens, dining areas, clean linens, clothing, and food.

(6) Pest Control. All necessary measures will be taken to prevent rodents and insects from entering the home. Should pests be found in the home, appropriate action will be taken to eliminate them.

(7) Grounds Maintenance. The grounds of the home will be kept orderly and reasonably free of litter, unused articles, and refuse.

(8) Garbage Storage and Removal. Garbage and refuse receptacles will be clean, durable, watertight, insect and rodent proof, and will be kept covered with tight-fitting lids. All garbage and solid waste will be disposed of at least weekly and in compliance with the current rules of the Department of Environmental Quality.

(9) Sewage Disposal. All sewage and liquid wastes will be disposed of in accordance with the Plumbing Code to a municipal sewage system where such facilities are available. If a municipal sewage system is not available, sewage and liquid wastes will be collected, treated, and disposed of in compliance with the current rules of the Department of Environmental Quality. Sewage lines, and septic tanks or other non-municipal sewage disposal systems where applicable, will be maintained in good working order.

(10) Biohazard Waste. Biohazard waste will be disposed of in compliance with the rules of the Department of Environmental Quality.

(11) Infection Control. Precautions will be taken to prevent the spread of infectious and/or communicable diseases as defined by the Centers for Disease Control and to minimize or eliminate exposure to known health hazards.

(a) In accordance with OAR 437, Division 2, Subdivision Z, Section 1910.1030 of the Oregon Occupational Safety and Health Code, staff will employ universal precautions whereby all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

(b) Bathroom facilities will be equipped with an adequate supply of toilet paper, soap, and towels.

(12) Infection Control for Pets and Other Household Animals. If pets or other household animals exist at the home, sanitation practices will be implemented to prevent health hazards.

(a) Such animals will be vaccinated in accordance with the recommendations of a licensed veterinarian. Proof of such vaccinations will be maintained on the premises.

(b) Animals not confined in enclosures will be under control and maintained in a manner that does not adversely impact residents or others.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0380
Resident Furnishings

(1) Bedrooms:

(a) Bedrooms for all household occupants will have been constructed as a bedroom when the home was built or remodeled under permit; be finished, with walls or partitions of standard construction which go from floor to ceiling, and a door which opens directly to a hallway or common use room without passage through another bed-

room or common bathroom; be adequately ventilated, heated and lighted with at least one operable window which meets the requirements of Section R310 of the Oregon Residential Specialty Code; have at least 70 square feet of usable floor space for each resident or 120 square feet for two residents and have no more than two persons per room;

(b) Providers, resident managers, or family members will not sleep in areas designated as living areas, nor share bedrooms with residents;

(c) There will be an individual bed for each resident consisting of a mattress in good condition and springs at least 36 inches wide. Cots, rollaway, bunks, trundles, couches, and folding beds may not be used for residents. Each bed will have clean bedding in good condition consisting of a bedspread, mattress pad, two sheets, a pillow, a pillowcase, and blankets adequate for the weather. Sheets and pillowcases will be laundered at least weekly, and more often if necessary. Waterproof mattress covers will be used for incontinent residents. Day care persons may not use resident beds;

(d) Each bedroom will have sufficient separate, private dresser and closet space for each resident's clothing and personal effects, including hygiene and grooming supplies. Residents will be allowed to keep and use reasonable amounts of personal belongings, and to have private, secure storage space. Drapes or shades for windows will be in good condition and allow privacy for residents;

(e) Bedrooms will be on ground level for residents who are non-ambulatory or have impaired mobility;

(f) Resident bedrooms will be in close enough proximity to provider to alert provider to night time needs or emergencies, or be equipped with a call bell or intercom.

(2) Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels and washcloths.

(3) Supplies Provided by Adult Foster Home. Sufficient supplies of soap, shampoo and toilet paper for all residents will be provided.

(4) Common Area Furniture. An adequate supply of furniture for resident use in living room, dining room, and other common areas will be maintained in good condition.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0385
Food Services

(1) Well-balanced Diet. Three nutritious meals will be served daily at times consistent with those in the community. Meals will be planned and served in accordance with the recommended dietary allowances found in the United States Department of Agriculture Food Guide Pyramid or as directed by a prescriber. Consideration will be given to cultural and ethnic backgrounds of residents in food preparation.

(2) Modified or Special Diets. An order from a Licensed Medical Professional will be obtained for each resident who, for health reasons, is on a modified or special diet. Such diets will be planned in consultation with the resident.

(3) Menus. Menus will be prepared at least one week in advance and will provide a sufficient variety of foods served in adequate amounts for each resident at each meal and adjusted for seasonal changes. Records of menus, as served, will be filed and maintained in the Adult Foster Home for three years. Resident preferences and requests will be considered in menu planning. Religious and vegetarian preferences will be reasonably accommodated.

(4) Meal Preparation. Meals will be prepared and served in the Adult Foster Home where residents live. Payment for meals eaten away from the Adult Foster Home for the convenience of the provider (e.g. restaurants, senior meal sites) is the responsibility of the provider. Meals and snacks as part of an individual recreational outing are the responsibility of the individual. Food preparation areas will be clean, free of obnoxious odors and in good repair.

(5) Supply of Food. Adequate supplies of staple foods, for a minimum of one week, and perishable foods, for a minimum of two days, will be maintained on the premises.

(6) Adequate Storage. Food will be stored, prepared, and served in accordance with the Department Food Sanitation Rules.

(a) All working refrigerators and freezers will have a thermometer in working order.

(b) Food storage areas and equipment must be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.

(7) Food Service Equipment. Equipment will be maintained in a safe and sanitary manner. Utensils, dishes and glassware will be maintained in a sufficient number to accommodate the licensed capacity of the Adult Foster Homes. Utensils, dishes, and glassware will be washed in hot soapy water, rinsed, and stored to prevent contamination. A dishwasher with sanicycle is recommended.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0390
Standards and Practices for Care and Services

(1) Caregiver Requirements. There must be a provider, resident manager or substitute caregiver on duty 24 hours per day in an Adult Foster Home in accordance with ORS 443.725(3).

(2) Medications and Prescriber's Orders:

(a) There must be a copy of a medication, treatment, or therapy order signed by a physician, nurse practitioner or other licensed prescriber in the resident's file for the use of any medications, including over the counter medications, treatments, and other therapies.

(b) A provider, resident manager or substitute caregiver will dispense medications, treatments, and therapies as prescribed by a physician, nurse practitioner or other licensed prescriber. Changes to orders for the dispensing and administration of medication or treatment will not be made without a written order from a physician, nurse practitioner or other licensed prescriber. A copy of the medication, treatment, or therapy order will be maintained in the resident's record. The provider, resident manager or substitute caregiver will promptly notify the resident's case manager of any request for a change in resident's orders for medications, treatments, or therapies.

(c) Each resident's medication will be clearly labeled with the pharmacist's label or the manufacturer's originally labeled container and kept in a locked location. The provider and/or provider's family medication will be stored in a separate locked location. All medication for pets or other animals will be stored in a separate locked location. Unused, outdated, or recalled medications will not be kept in the Adult Foster Home and will be disposed in a manner to prevent diversion into the possession of people other than for whom it was prescribed. The provider will document disposal of all unused, outdated and or recalled medication on residents' individual drug disposal forms.

(d) Medications will not be mixed together in another container prior to administration except as packaged by the pharmacy or by physician order;

(e) A written medication administration record (MAR) for each resident will be kept of all medications administered by the caregiver to that resident, including over the counter medications. The MAR will indicate name of medication, dosage and frequency of administration, route or method, dates and times given, and will be immediately initialed by the person dispensing using only blue or black indelible ink. Treatments, therapies and special diets must be immediately documented on the medication administration record including times given, type of treatment or therapy, and initials of the person giving it using only blue or black indelible ink. The medication administration record will have a legible signature for each set of initials using only blue or black indelible ink;

(f) The MAR will include documentation of any known allergy or adverse reactions to a medication, and documentation and an explanation of why a PRN medication was administered and the results of such administration;

(g) Self-administration of medication. For any resident who is self-administering medication the resident's individual record must include the following:

(A) Documentation that the resident has been trained for self administering of prescribed medication or treatment or that the prescriber has provided documentation that training for the resident is unnecessary;

(B) Documentation that the resident is able to manage his or her own medication regimen and will keep medications stored in an area that is inaccessible to others and locked;

(C) Documentation of retraining when there is a change in dosage, medication and time of delivery;

(D) Documentation of review of self-administration of medication as part of the Personal Care Plan process; and

(E) Documentation of a current prescriber order for self-administration of medication.

(h) Injections may be self-administered by the resident, or administered by a relative of the resident, a currently licensed registered nurse, a licensed practical nurse under registered nurse supervision, or providers who have been trained and are monitored by a physician or delegated by a registered nurse in accordance with administrative rules of the Board of Nursing chapter 851, division 047. Documentation regarding the training or delegation will be maintained in the resident's record;

(3) Initial Personal Care Plan. The Initial Personal Care Plan will be developed within 24 hours of admission to the Adult Foster Home.

(4) Personal Care Plan. In accordance with Standards for Adult Mental Health Services, OAR 309-032-0535 Definitions (3) Case management (22) Personal Care Plan and OAR 309-032-0545 Adult Mental Health Services (1)(2) the Provider will develop the PCP in collaboration with the resident and other individuals as appropriate, including the resident's case manger, and guardian as applicable. The Personal Care Plan for an individual resident will be reviewed and updated by the personal care plan team every 180 days or more frequently as necessary in accordance with OAR 309-032-0545 Adult Mental Health Services (2)(g);

(a) The individual's case manager or other designated person will review and update the individual's personal care services prescription and status as needed;

(b) If the team agrees that interim changes in the Personal Care Plan are required, the case manager will make the changes.

(5) Delegation of Nursing Care Tasks. Nursing tasks may be delegated by a registered nurse to providers and other caregivers only in accordance with administrative rules of the Board of Nursing chapter 851, division 47. This includes but is not limited to the following conditions:

(a) The registered nurse has assessed the individual's condition to determine there is not a significant risk to the individual if the provider or other caregiver performs the task;

(b) The registered nurse has determined the provider or other caregiver is capable of performing the task;

(c) The registered nurse has taught the provider or caregiver how to do the task;

(d) The provider or caregiver has satisfactorily demonstrated to the registered nurse the ability to perform the task safely and accurately;

(e) The registered nurse provides written instructions for the provider or caregiver to use as a reference;

(f) The provider or caregiver has been instructed that the task is delegated for this specific person only and is not transferable to other individuals or taught to other care providers;

(g) The registered nurse has determined the frequency for monitoring the provider or caregiver's delivery of the delegated task; and

(h) The registered nurse has documented a Personal Care Plan for the individual including delegated procedures, frequency of registered nurse follow-up visits, and signature and license number of the registered nurse doing the delegating.

(6) Resident Records. An individual record will be developed, kept current, and available on the premises for each resident admitted to the Adult Foster Home:

(a) General Information:

(A) The provider will maintain a record for each individual in the home. The record must include:

(i) The resident's name, previous address, date of entry into Adult Foster Home, date of birth, sex, marital status, religious preference, preferred hospital, Medicaid and/or Medicare numbers where applicable, guardianship status, and;

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

(I) The Resident's legal representative, family, advocate or other significant person;

(II) The resident's preferred primary health provider designated back up health care provider and/or clinic;

(III) The resident's preferred dentist;

(IV) The resident's day program or employer, if any;

(V) The residents case manager; and

(VI) Other agency representatives providing services to the resident.

(B) Resident records will be available to representatives of the Department conducting inspections or investigations, as well as to residents, their authorized representative or other legally authorized persons;

(C) Record Retention. Original resident records will be kept for a period of three years after discharge when a resident no longer resides in the Adult Foster Home.

(D) In all other matters pertaining to confidential records and release of information, providers will comply with ORS 179.505.

(b) Medical Information:

(A) History of physical, emotional and medical problems, accidents, illnesses or mental status that may be pertinent to current care;

(B) Current orders for medications, treatments, therapies, use of restraints, special diets and any known food or medication allergies;

(C) Completed medication administration records from the license review period;

(D) Name and claim number of medical insurance, and any pertinent medical information such as hospitalizations, accidents, immunization records including Hepatitis B status and previous TB tests, incidents or injuries affecting the health, safety or emotional well-being of any resident.

(c) Resident Account Record:

(A) Resident's Income Sources.

(B) Refer to resident's personal care plan with supporting documentation from the income sources to be maintained in the resident's individual record.

(C) Resident's room and board and service costs. Resident or designated guardian will agree to specific costs for room and board and services within the pre-set limits of the state contract. A copy will be given to the resident, resident's guardian, and the original in the resident's individual record.

(D) Resident's record of discretionary funds.

(d) If a resident maintains custody and control of their discretionary funds then no accounting record is required.

(e) If a designee of the Adult Foster Home maintains custody and control of a resident's discretionary fund, a signed and dated account and balance sheet must be maintained with supporting documentation for expenditures $10 and greater. The Adult Foster Home designee must have specific written permission to manage an individual resident's discretionary fund.

(f) Personal Care Plan. The resident's PCP is prepared by the PCP Team. The PCP Team addresses each resident's support needs, each service provider's program plan and prepares PCP for the resident. The PCP will be developed at the time of admission, reviewed every 180 days and updated at least annually or when indicated by changing resident needs. The PCP will describe the resident's needs and capabilities including when and how often care and services will be provided and by whom. The PCP will include the provision of at least six hours of activities each week that are of interest to the resident, not including television or movies made available to the resident by the provider.

(A) Description of residents strengths and abilities;

(B) The activities of daily living where the resident requires full assistance;

(C) The activities of daily living where the resident requires partial assistance with encouragement and training;

(D) Other areas or concerns;

(E) Any mental and/or physical disabilities or impairments relevant to the service needs of the resident;

(F) The ability of the resident to exit from the Adult Foster Home in an emergency and the time required to exit;

(G) Instruction and documentation of tasks delegated to the provider by the registered nurse, with the name and license number of the delegating registered nurse; and

(H) Dates of review and signature of person preparing the PCP.

(g) House Rules: Develop written house rules regarding hours, visitors, use of tobacco and alcohol, meal times, use of telephones and kitchen, monthly charges and services to be provided and policies on

refunds in case of departure, hospitalization or death. House rules will be discussed with residents and their families at the time of arrival and be posted in a conspicuous place in the AFH. House rules are subject to review and approval by the Department or designee and may not violate resident's rights as stated in ORS 430.210. A copy of the written house rules with documentation that the rules have been discussed with the resident.

(h) Unusual Incidents: A written incident report of all unusual incidents relating to the Adult Foster Home including but not limited to resident care. The incident report will include how and when the incident occurred, who was involved, what action was taken by staff, and the outcome to the resident. In compliance with HIPAA rules, only one resident's name will be used on each incident report. Separate reports will be written for each resident involved in an incident. A copy of the incident report will be submitted to the CMHP within five working days of the incident. The original will be placed in the residents record.

(i) General Information: Any other information or correspondence pertaining to the resident;

(j) Progress Notes. Progress notes will be maintained within each resident's record and document significant information relating to all aspects of the resident's functioning and progress toward desired outcomes as identified in the resident's individual personal care plan. A progress note will be entered in the resident's record at least once each month.

(7) Residents' Bill of Rights.

(a) The Provider will guarantee the Residents' Bill of Rights as described in ORS 443.739. The provider will post them in a location that is accessible to residents and parents, guardians, and advocates. A copy of the Residents' Bill of Rights will be given to each resident, parent, guardian, and advocate along with a description of how to exercise these rights.

(b) The provider will explain and document in the resident's file that a copy of the Residents' Bill of Rights is given to each resident at admission, and is posted in a conspicuous place including the name and phone number of the office to call in order to report complaints.

(8) Physical Restraints. Physical Restraints are not allowed. Providers, resident managers, or substitute caregivers will not employ physical restraints for individuals receiving personal care services authorized or funded through the Office of Mental Health and Addiction Services.

(9) General Practices. The provider will:

(a) Conspicuously post the State license and Abuse and Complaint poster where it can be seen by residents;

(b) Cooperate with Department personnel or designee in complaint investigation procedures, abuse investigations and protective services, planning for resident care, application procedures and other necessary activities, and allow access of Department personnel to the AFH, its residents, and all records;

(c) Give care and services, as appropriate to the age and condition of the resident(s), and as identified on the PCP. The provider will be responsible for ensuring that physicians' orders and those of other medical professionals are followed, and that the resident's physicians and other medical professionals are informed of changes in health status and/or if the resident refuses care;

(d) In the provider's absence, the provider will have a resident manager or substitute caregiver on the premises to provide care and services to the residents. For absences greater than 72 consecutive hours, the CMHP must be notified of the name(s) of the substitute caregiver(s)for the provider or resident manager.

(e) A provider, resident manager, or substitute caregiver will be present in the home at all times.

(f) Allow and encourage residents to exercise all civil and human rights accorded to other citizens;

(g) Not allow or tolerate physical, sexual, or emotional abuse or punishment, or exploitation, or neglect of residents;

(h) Provide care and services as agreed to in the PCP;

(i) Keep information related to resident(s) confidential as required under ORS 179.050;

(j) Assure that the number of residents requiring nursing care does not exceed the provider's capability as determined by the CMHP and/or OMHAS;

(k) Not admit individuals who are clients of the Department Seniors and People with Disabilities without the express permission of the Department or their designee;

(l) Notify the Department prior to a closure and give residents, families, and CMHP staff 30 days written notice of the planned change except in circumstances where undue delay might jeopardize the health, safety or well-being of residents, providers or caregivers. If a provider has more than one AFH, residents cannot be shifted from one AFH to another without the same period of notice unless prior approval is given and agreement obtained from residents, family members and CMHP;

(m) Exercise reasonable precautions against any conditions which could threaten the health, safety or welfare of residents;

(n) Immediately notify the appropriate PCP Team members (in particular the CMHP representative and family/guardian) if: the resident has a significant change in their medical status; the resident has an unexplained or unanticipated absence from the Adult Foster Home; the provider becomes aware of alleged or actual abuse of the resident; the resident has a major behavioral incident, accident, illness, hospitalization; the resident contacts, or is contacted by, the police; or the resident dies and follow-up with an incident report.

(10) Incident Reports. The provider will write an incident report for any unusual incident and forward a copy of the incident report to the CMHP within five working days of the incident. Any incident that is the result of or suspect of abuse will be reported to the Office of Investigations and Training within 24 hours of occurrence.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Renumbered from 309-040-0050(8)-(10); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 7-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 4-2002, f. 2-26-02, cert. ef. 2-27-02; Renumbered from 309-040-0052, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0395
Standards for Admission, Transfers, Respite, Discharges, and Closures

(1) Admission. A provider will only accept a resident into their Adult Foster Home with a referral from, or the prior written approval of, staff of the CMHP or Department. At the time of the referral, a provider will be given complete information about the case history of a resident as it relates to behavior, skill level, medical status, or other relevant information. The provider will retain the right to deny admission of any person if they feel the person cannot be managed effectively in the Adult Foster Home, or for any other reason not specifically prohibited by this rule. Adult Foster Homes will not be used as a site for foster care for children, adults from other agencies, or any type of shelter or day care without the written approval of the CMHP or the Department.

(2) Transfers:

(a) A resident may not be transferred by a provider to another Adult Foster Home or moved out of the Adult Foster Home without 30 days advance written notice to the resident, the resident's legal representative, guardian or conservator, and the CMHP stating reasons for the transfer as provided in ORS 443.739(18) and OAR 411-088-0070, and the resident's right to a hearing as provided in ORS 443.738(11)(b) and 411-088-0080, except where undue delay might jeopardize the health, safety or well-being of the resident or others, for a medical emergency, or to protect the welfare of the resident or other residents. Residents may only be transferred by a provider for the following reasons:

(A) Behavior that poses a significant danger to the resident or others;

(B) Failure to make payment for care;

(C) The Adult Foster Home has had its license revoked, not renewed, or voluntarily surrendered; or

(D) The resident's care needs exceed the ability of the provider.

(b) Residents who object to the transfer will be given the opportunity for hearing as provided in ORS 443.738(11)(b) and OAR 411-088-0080. Participants may include the resident, and at the resident's request, the provider, a family member and CMHP staff member.

(3) Respite. Providers will not exceed the licensed capacity of their Adult Foster Home. However, respite care of no longer than two weeks duration may be provided a person if the addition of the respite person does not cause the total number of residents to exceed five. Thus, a provider may exceed the licensed number of residents by one

respite resident, for two weeks or less, if approved by the CMHP or Department, and if the total number of residents does not exceed five.

(4) Discharge:

(a) A provider may only discharge a resident for valid reasons equivalent to those for transfers stated in paragraphs (2)(a)(A) through (D) of this rule. The provider will give at least 30 days written notice to a resident and the Department before termination of residency, except where undue delay might jeopardize the health, safety or well-being of the resident or others;

(b) The provider will promptly notify staff of the CMHP or Department if a resident gives notice or plans to leave the Adult Foster Home or if a resident abruptly leaves.

(5) Closing. Providers will notify the Department prior to a voluntary closure of an Adult Foster Home, and give residents, families, and the CMHP, 30 days written notice, except in circumstances where undue delay might jeopardize the health, safety or well-being of residents, providers or caregivers. If a provider has more than one Adult Foster Home, residents cannot be shifted from one house to another house without the same period of notice unless prior approval is given and agreement obtained from residents, family members, and the CMHP.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Former sections (3)(a)-(c) renumbered to 309-040-0057; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 7-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 4-2002, f. 2-26-02, cert. ef. 2-27-02; Renumbered from 309-040-0055, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0400
Inspections

(1) Department or Designee Inspections. The Department or designee will conduct an inspection of an Adult Foster Home:

(a) Prior to issuance of a license;

(b) Upon receipt of an oral or written complaint of violations that threaten the health, safety, or welfare of residents; or

(c) Anytime the Department has probable cause to believe that an Adult Foster Home has violated a regulation or provision of these rules or is operating without a license.

(2) Department Inspections. The Department may conduct inspections of an Adult Foster Home:

(a) Anytime such inspections are authorized by these rules and any other time the CMHP or Department considers it necessary to determine if an Adult Foster Home is in compliance with these rules or with conditions placed upon the license;

(b) To determine if cited deficiencies have been corrected; and

(c) For the purpose of monitoring of the residents' care.

(3) State or Local Fire Inspectors. State or local fire inspectors will be permitted access to enter and inspect the Adult Foster Home regarding fire safety upon request of the CMHP or Department.

(4) Full Access by Department and/or CMHP. The Department and/or CMHP staff will have full access and authority to examine, among other things, facility and resident records and accounts, and the physical premises, including the buildings, grounds, equipment, and any vehicles.

(5) Interviews. The Department or CMHP staff will have authority to interview the provider, resident manager, caregiver, and residents. Interviews will be confidential and conducted in private, and will be confidential except as considered public record under ORS 430.763.

(6) Authorized Entrance to Adult Foster Home. Providers must authorize resident managers and substitute caregivers to permit entrance by the Department or CMHP staff for the purpose of inspection and investigation.

(7) Authority to Conduct Inspections With or Without Advance Notice. The Department and/or CMHP staff has authority to conduct inspections with or without advance notice to the provider, staff, or a resident of the Adult Foster Home. The Department and/or CMHP will not give advance notice of any inspection if they believe that notice might obstruct or seriously diminish the effectiveness of the inspection or enforcement of these rules.

(8) Search Warrant. If the Department and/or CMHP staff is not permitted access or inspection, a search warrant may be obtained.

(9) Respect Private Possessions. The inspector will respect the private possessions and living area of residents, providers, and caregiver while conducting an inspection.

(10) Confidential Information. Completed reports on inspections, except for confidential information, will be available to the public, upon written request to the Department and/or CMHP, during business hours.

(11) Investigate Allegations of Abuse. For individuals receiving services authorized and/or funded by the Office of Mental Health and Addiction Services, the Department or its designee will investigate allegations of abuse as defined in ORS 430.735 to 430.765.

(12) Alleged Abuse. When abuse is alleged or death of an individual has occurred and a law enforcement agency, or the Department and/or its designee, has determined to initiate an investigation, the provider will not conduct an internal investigation without prior authorization from the Department. For the purposes of this section, an internal investigation is defined as conducting interviews of the alleged victim, witness, the alleged perpetrator or any other persons who may have knowledge of the facts of the abuse allegation or related circumstances; reviewing evidence relevant to the abuse allegation, other than the initial report; or any other actions beyond the initial actions of determining:

(a) If there is reasonable cause to believe that abuse has occurred; or

(b) If the alleged victim is in danger or in need of immediate protective services; or

(c) If there is reason to believe that a crime has been committed; or

(d) What, if any, immediate personnel actions will be taken.

(13) Completion of Abuse Investigation. The Department or its designee will complete an Abuse Investigation and Protective Services Report according to OAR 410-009-0120(1)(2)(3)(4). The report will include the findings based upon the abuse investigation as defined in OAR 410-009-0060(11) Inconclusive, (14) Not Substantiated, (16) Substantiated.

(14) Provider Notified of Completion of Investigation. When the provider has been notified of the completion of the abuse investigation, a provider may conduct an investigation without further Department approval to determine if any other personnel actions are necessary.

(15) Abuse Investigation and Protective Services Report. Upon completion of the investigation report according to OAR 410-009-0130, the sections of the report which are public records and not exempt from disclosure under the public records law will be provided to the appropriate provider. The provider will implement the actions necessary within the deadlines listed to prevent further abuse as stated in the report.

(16) Prohibition of Retaliation. A provider will not retaliate against any person who reports in good faith suspected abuse, or against the resident with respect to the report.

(17) Retaliatory Liability. In accordance with ORS 430.755 any provider who retaliates against any person because of a report of suspected abuse or neglect may be liable according to ORS 430.755, in a private action to that person for actual damages and, in addition, a penalty in accordance with ORS 443.775(10) not withstanding any other remedy provided by law. The authority of the Director to impose civil penalties and the factors to be considered will be in accordance with ORS 443.790.

(18) Adverse Action Creates a Presumption of Retaliation. In accordance with OAR 410-009-0140(3) Adverse Action, any adverse action creates a presumption of retaliation if taken within 90 days of a report of abuse. For purposes of this subsection, "adverse action" means any action taken by a community facility, community program or person involved in a report against the person making the report or against the adult because of the report and includes but is not limited to:

(a) Discharge or transfer from the Adult Foster Home, except for clinical reasons;

(b) Discharge from or termination of employment;

(c) Demotion or reduction in remuneration for services; or

(d) Restriction or prohibition of access to the community facility or its residents.

(19) Adverse Action Limits. Adverse action may also be evidence of retaliation after 90 days even though the presumption no longer applies.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0060, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0405
Procedures for Correction of Violations

(1) Conference Request. At any time after receipt of a notice of violations or an inspection report, the licensee or OMHAS may request a conference, in writing. The conference will be scheduled within ten days of a request by either party. The purpose of the conference is to discuss the violations stated in the notice of violation and to provide information to the licensee to assist the licensee in complying with the requirements of the rules. The written request by a licensee or OMHAS for a conference will not extend any previously established time limit for correction.

(2) Notification of Correction. The licensee will notify OMHAS of correction of violations, in writing, no later than the date specified in the notice of violation.

(3) No Report of Compliance. If, after inspection of the Adult Foster Home, the violations have not been corrected by the date specified in the notice of violation or if OMHAS has not received a report of compliance, OMHAS may institute one or more of the following actions:

(a) Imposition of an administrative sanction that may include revocation, suspension, placement of conditions on the license or non-renewal of a license as deemed appropriate by OMHAS.

(b) Filing of a criminal complaint.

(4) Serious and Immediate Danger. If residents are in serious and immediate danger, the license may be immediately suspended or revoked and arrangements made to move the residents.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0070, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0410
Residents' Rights, Complaints, and Grievances

(1) Residents' Bill of Rights.

(a) The Provider will guarantee the Residents' Bill of Rights as described in ORS 443.739. The provider will post them in a location that is accessible to residents, parents/guardian/advocates. A copy of the Residents' Bill of Rights will be given to each resident and parent/guardian/advocate along with a description of how to exercise these rights.

(b) The provider will explain and document in the resident's file that a copy of the Resident's Bill of Rights is given to each resident at admission, and is posted in a conspicuous place including the name and phone number of the office to call in order to report complaints. The Bill of Rights states each resident has the right to:

(A) Be treated as an adult, with respect and dignity;

(B) Be encouraged and assisted to exercise constitutional and legal rights as a citizen including the right to vote and be informed of all house rules;

(C) Receive appropriate care and services and prompt medical care as needed. Be informed of the resident's medical condition and the right to consent to or refuse treatment;

(D) Adequate personal privacy and privacy to associate and communicate privately with any person of choice, such as family members, friends, advocates, and legal, social service and medical professionals, send and receive personal mail unopened, and engage in telephone conversations as explained in 309-040-0365(17); have medical and personal information kept confidential:

(E) Have access to and participate in activities of social, religious, and community groups;

(F) Be able to keep and use a reasonable amount of personal clothing and belongings and to have a reasonable amount of private, secure storage space.

(G) Be free of discrimination in regard to race, color, national origin, sex, religion, sexual orientation, or disability;

(H) Manage his/her financial affairs unless legally restricted. Be free from financial exploitation. The provider will not charge or ask for application fees or nonrefundable deposits and will not solicit, accept or receive money or property from a resident other than the amount agreed to for services;

(I) A safe and secure environment;

(J) Written notices prior to rate increases and evictions;

(K) A written agreement regarding services to be provided and agreed upon rates;

(L) Voice suggestions, complaints, or grievances without fear of retaliation;

(M) Freedom from training, treatment, chemical or physical restraints except as agreed to, in writing, in a resident's PCP. Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner;

(N) Be allowed and encouraged to learn new skills, to act on their own behalf to their maximum ability, and to relate to residents in an age appropriate manner;

(O) An opportunity to exercise choices including such areas as food selection, personal spending, friends, personal schedule, leisure activities, and place of residence;

(P) Freedom from punishment. Behavior intervention programs must be approved in writing on the resident's PCP;

(Q) Freedom from abuse and neglect;

(R) The opportunity to contribute to the maintenance and normal activities of the household; and

(S) Access and opportunity to interact with persons with/without disabilities.

(T) The right not to be transferred or moved out of the adult foster home without 30 days' advance written notice and an opportunity for a hearing as described in ORS 443.738(11)(b) and OAR 411-088-0080. A provider may transfer or discharge a resident only for medical reasons including a medical emergency described in ORS 443.738(11)(a), or for the welfare of the resident or other residents, or for nonpayment.

(2) Complaints and Grievances. Any person who believes these rules have been violated may file a complaint with the Department and/or CMHP. OMHAS and/or CMHP will investigate any complaint or grievance regarding the AFH.

(3) Complaint and Grievance Notice. The OMHAS and/or CMHP will furnish each Adult Foster Home with a Complaint and Grievance Notice, which must be posted in a conspicuous place stating the telephone number of OMHAS and the CMHP and the procedure for making complaints or grievances.

(4) Complaint and Grievance Actions. A copy of all Adult Foster Home complaints or grievances will be maintained by OMHAS. All complaints or grievances and actions taken on the complaint or grievance, indexed by the name of the provider, will:

(a) Be placed into the public file at OMHAS. Information regarding the investigation of the complaint or grievance will not be filed in the public file until the investigation has been completed;

(b) Protect the privacy of the complainant or grievant and the resident; and

(c) Treat the names of the witnesses as confidential information.

(5) Substantiated Complaints or Grievances. Providers who acquire substantiated complaints or grievances pertaining to the health, safety or welfare of residents may have their licenses suspended, revoked or not renewed, or may have conditions placed on the license.

(6) Retaliation Against a Resident. The Adult Foster Home provider, resident manager, or caregiver will not retaliate in any way against any resident after a complaint or grievance has been filed with the Department. Retaliation may include, but is not limited to:

(a) Increasing charges or threatening to increase charges;

(b) Decreasing or threatening to decrease services, rights or privileges;

(c) Threatening to increase charges or decrease services, rights or privileges;

(d) Taking or threatening to take any action to coerce or compel the resident to leave the Adult Foster Home; or

(e) Abusing, harassing, or threatening to abuse or harass a resident in any manner.

(7) Retaliation Against Others. A complainant, grievant, witness or caregiver of an Adult Foster Home will not be subject to retaliation by a provider, or resident manager, or substitute caregiver for making a report or being interviewed about a complaint or being a witness. Retaliation may include, but is not limited to, caregiver dismissal or

harassment, or restriction of access to either the Adult Foster Home or a resident.

(8) Immunity. The complainant will have immunity from any civil or criminal liability with respect to the making or content of a complaint or grievance made in good faith.

(9) Public Complaint Files. Any person has the right to inspect and receive a photocopy of the public complaint files, including protective services files, maintained by the Department upon written request subject to the Department's procedures, ORS 192.410 through 192.505, and photocopy charges for public record requests.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0065, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0415
Administrative Sanctions and Conditions

(1) Administrative Sanctions. An administrative sanction may be imposed for non-compliance with these rules. An administrative sanction includes one or more of the following actions:

(a) Attachment of conditions to a license;

(b) Civil penalties;

(c) Denial, suspension, revocation, or non-renewal of license.

(2) Notice of Intent. If OMHAS imposes an administrative sanction, it will serve a Notice of Intent of the administrative sanction upon the licensee personally or by certified mail.

(3) Notice of Administrative Sanction. The notice of administrative sanction will state:

(a) Each sanction imposed;

(b) A short and plain statement of each condition or act that constitutes a violation;

(c) Each statute or rule allegedly violated;

(d) A statement of the licensee's right to a contested case hearing;

(e) A statement of the authority and jurisdiction under which the hearing is to be held;

(f) A statement that OMHAS files on the subject of the contested case automatically become part of the contested case record upon default for the purpose of proving a prima facie case; and

(g) A statement that the notice becomes a final order upon default if the licensee fails to request a hearing within the specified time.

(4) Hearing. If an administrative sanction is imposed for reason other than abuse, neglect, or exploitation, a hearing will precede it if the licensee requests the hearing in writing within 60 days after receipt of the notice per ORS Chapter 183.

(5) Failure to Request a Hearing. If a licensee fails to request in writing a hearing within 60 days, the Notice of Administrative Sanction will become a Final Order of OMHAS by default.

(6) Immediate Action. OMHAS may immediately suspend, revoke, or not renew a license for a substantiated finding of abuse, neglect, or exploitation of a resident. The licensee may submit a request, in writing, for a contested case hearing within 60 days of the notice of intent of suspension, revocation or non-renewal.

(7) Resident Removal. When a license is denied, suspended, revoked, or not renewed, OMHAS will work with the CMHP to arrange for residents to move for their protection.

(8) Conditions on License. Conditions may be attached to a license upon a finding that:

(a) Information on the application or initial inspection requires a condition to protect the health and safety of residents, pending further action by OMHAS or OMHAS designee;

(b) There exists a threat to the health, safety, and welfare of a resident, pending further action by OMHAS or OMHAS designee;

(c) There is reliable evidence of abuse of an adult, pending further action by OMHAS or OMHAS designee;

(d) The Adult Foster Home is not being operated in compliance with these rules, pending further action by OMHAS or OMHAS designee; or

(e) The provider is licensed to care for a specific person only and further placements may not be made to the Adult Foster Home.

(9) Conditions on Licensee. Conditions which may be imposed on a licensee include but are not limited to:

(a) Restricting the maximum capacity of the Adult Foster Home;

(b) Restricting the number and impairment level of residents allowed based upon the capacity of the caregivers to meet the health and safety needs of all residents;

(c) Requiring an additional caregiver or caregiver qualifications;

(d) Requiring additional training of caregivers;

(e) Requiring additional documentation as deemed necessary by OMHAS;

(f) Restricting a provider from opening an addition Adult Foster Home; and/or

(g) Suspending admissions to the Adult Foster Home.

(10) Notification of Conditions. The provider must be notified, in writing, of any conditions imposed, the reason for the conditions, and be given an opportunity to request a hearing under ORS Chapter 183.

(11) Review by OMHAS. In addition to, or in lieu of, a contested case hearing, a provider may request, in writing, a review by the OMHAS administrator or designee of conditions imposed by the CMHP or OMHAS. The review does not diminish the provider's right to a hearing.

(12) Length of Conditions. Conditions may be imposed for the extent of the license period (one year), extended to the next license period, or limited to some other shorter period of time as deemed necessary by OMHAS. If the conditions correspond to the licensing period, the reasons for the conditions will be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the conditions will be indicated on the attachment to the license.

(13) Hearing Rights. Hearing rights are in accordance with ORS 183.310 to 183.550.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0075, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0420
Denial, Suspension, Revocation or Non-renewal of License

(1) Causative Action. OMHAS will deny, suspend, revoke, or refuse to renew a license where it finds:

(a) There has been substantial failure to comply with these rules or where there is substantial non-compliance with local codes and ordinances, or any other state or federal law or rule applicable to the health and safety of residents in an Adult Foster Home; or

(b) The applicant or provider has been convicted of one or more crimes described in the Criminal Record Check:

(A) The applicant or provider has had a certificate or license to operate a foster home or residential care facility denied, suspended, revoked or refused to be renewed in this or any other state/county within three years preceding the present action if the denial, suspension, revocation or refusal to renew was due in any part to abuse of an adult, creating a threat to the residents or failure to possess physical health, mental health or good personal character;

(B) If the denial, suspension, revocation or refusal to renew occurred more than three years from the present action, the applicant or provider is required to establish to OMHAS by clear and convincing evidence his/her ability and fitness to operate an Adult Foster Home. If the applicant or provider does not meet this burden, then OMHAS will deny, suspend, revoke or refuse to renew the license;

(C) The applicant or provider is associated with a person whose license for a foster home or residential care facility was denied, suspended, revoked or refused to be renewed due to abuse of an adult, or failure to possess physical health, mental health or good personal character within three years preceding the present action, unless the applicant or provider can demonstrate to OMHAS by clear and convincing evidence that the person does not pose a threat to the residents;

(D) For purposes of this subsection, an applicant or provider is "associated with" a person as described above, if the applicant or provider:

(i) Resides with the person;

(ii) Employs the person in the Adult Foster Home;

(iii) Receives financial backing from the person for the benefit of the Adult Foster Home;

(iv) Receives managerial assistance from the person for the benefit of the Adult Foster Home; or

(v) Allows the person to have access to the Adult Foster Home.

(E) For purposes of this section only, "present action" means the date of the notice of denial, suspension, revocation or refusal to renew.

(2) Causative Action by Provider. The Department may deny, suspend, revoke, or refuse to renew an Adult Foster Home license if the applicant or provider:

(a) Submits fraudulent or untrue information to OMHAS;

(b) Has a history of, or demonstrates financial insolvency, such as filing for bankruptcy, foreclosure, eviction due to failure to pay rent, or termination of utility services due to failure to pay bill(s);

(c) Has a prior denial, suspension, revocation or refusal to renew a certificate or license to operate a foster home or residential care facility in this or any other state/county;

(d) Has threatened the health, safety, or welfare of any resident;

(e) Has a substantiated finding of abuse of an adult;

(f) Has a medical or psychiatric problem, which interferes with the ability to provide care;

(g) Refuses to allow access and inspection;

(h) Fails to comply with a final order of OMHAS to correct a violation of the rules for which an administrative sanction has been imposed; or

(i) Fails to comply with a final order of OMHAS imposing an administrative sanction.

(j) Fails to report knowledge of the illegal actions of or disclose the known criminal history of a provider, resident manager, substitute caregiver, or volunteer of the Adult Foster Home.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0090, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0425
Removal of Residents

(1) Order to Move. OMHAS may order the removal of residents from an Adult Foster Home to an alternative placement on the following grounds:

(a) When a violation of these rules is not corrected after time limit specified in notice;

(b) There is a violation of a resident's rights;

(c) The number of residents currently in the Adult Foster Home exceeds the maximum licensed capacity of the Adult Foster Home;

(d) The Adult Foster Home is operating without a license; or

(e) There is evidence of abuse of an adult that presents a serious and immediate danger to residents.

(2) Resident Assistance. The resident will be given assistance in locating and visiting alternative placements by the CMHP, if needed, and will have the right to contest the move as provided in ORS 443.738(11)(b) and OAR 411-088-0080.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Renumbered from 309-040-0085; MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; MHD 7-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 4-2002, f. 2-26-02, cert. ef. 2-27-02; Renumbered from 309-040-0092, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0430
Conditions

(1) Attachment to License. Conditions will be attached to a license upon a finding that:

(a) Information on the application or initial inspection requires a condition to protect the health and safety of residents;

(b) There exists a threat to the health, safety, and welfare of a resident;

(c) There is reliable evidence of abuse of an adult;

(d) The Adult Foster Home is not being operated in compliance with these rules; or

(e) The provider is licensed to care for a specific person(s) only and further placements may not be made to the Adult Foster Home.

(2) Notification of Conditions. The provider must be notified, in writing, of any conditions imposed, the reason for the conditions, and be given an opportunity to request a hearing under ORS Chapter 183.

(3) Hearing Rights. In addition to, or in lieu of, a contested case hearing, a provider may request in writing a review by the OMHAS administrator or designee of conditions imposed by the CMHP or OMHAS. The review does not diminish the provider's right to a hearing.

(4) Length of Conditions. Conditions will be imposed for the extent of the license period (one year), extended to the next license period or limited to some other shorter period of time as deemed necessary by OMHAS. If the conditions correspond to the licensing period, the reasons for the conditions will be considered at the time of renewal to determine if the conditions are still appropriate. The effective date and expiration date of the conditions will be indicated on the attachment to the license.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0093, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0435
Criminal Penalties

(1) Unlicensed. Operating an Adult Foster Home without a license is punishable as a Class C misdemeanor.

(2) Refusal to Comply. Refusing to allow any of the following is punishable as a Class B misdemeanor:

(a) Department access to the Adult Foster Home for inspection or investigation;

(b) Department access to residents in order to interview residents privately or to review records; or

(c) State and local fire inspector access to the Adult Foster Home regarding fire safety.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0095, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0440
Civil Penalties

(1) Penalties for Other than Abuse. Civil penalties, for other than substantiated allegations of abuse, will not exceed $100 per violation with a maximum of $250 may be assessed for violation of these rules, with the exception of substantiated abuse findings.

(2) Penalties for Abuse. Civil penalties of a maximum of $1000 per occurrence may be assessed for each substantiated abuse finding.

(3) Other Penalties. In addition to any other liability or penalty, OMHAS may impose a penalty for any of the following:

(a) Operating an Adult Foster Home without a license;

(b) Exceeding the number of residents identified on the license;

(c) The Provider fails to achieve satisfactory compliance with the requirements of these rules within the time specified, or fails to maintain such compliance;

(d) The Adult Foster Home is unable to provide an adequate level of care to residents;

(e) There is retaliation or discrimination against a resident, family, employee, or any other person for making a complaint against the Adult Foster Home;

(f) The provider fails to cooperate with OMHAS, physician, registered nurse, or other health care professional in carrying out a resident's care plan; or

(g) Other violations are found on two consecutive inspections of an Adult Foster Home after a reasonable amount of time has been allowed for the elimination of the violations.

(4) Penalty Due. Any civil penalty imposed under this section will become due and payable when the provider incurring the penalty receives a notice in writing from OMHAS. The notice will be sent by registered or certified mail and will include:

(a) A reference to the particular sections of the statute, rule, standard, or order involved;

(b) A short and plain statement of the matter asserted or charged;

(c) A statement of the amount of the penalty or penalties imposed; and

(d) A statement of the right to request a hearing.

(5) Application for Hearing. The provider to whom the notice is addressed will have 60 days from the date of the notice of intent in which to make written application for a hearing.

(6) Hearings. All hearings will be conducted according to the applicable provisions of ORS Chapter 183.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0097, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0445
Public Information

(1) Current Information. The Department will maintain current information on all licensed Adult Foster Homes and will make that information available to prospective residents, their families, and other interested members of the public.

(2) Current Information Content. The information will include:

(a) The location of the Adult Foster Home;

(b) A brief description of the physical characteristics of the home;

(c) The name and mailing address of the provider;

(d) The license classification of the home and the date the provider was first licensed to operate that home;

(e) The date of the last inspection, the name and telephone number of the office that performed the inspection and a summary of the findings;

(f) Copies of all complaint investigations involving the home, together with the findings of and actions taken by the Department;

(g) Any license conditions, suspensions, denials, revocations, civil penalties, exceptions or other actions taken by the department involving the home; and

(h) Whether care is provided primarily by the licensed provider, a resident manager, or other arrangement.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0098, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0450
Adjustment, Suspension or Termination of Payment

(1) Causative Actions. The CMHP or Department may adjust, suspend, or terminate payment(s) to a provider when any of the following conditions occur:

(a) The provider's Adult Foster Home license is revoked, suspended, or terminated;

(b) Upon a finding that the provider is failing to deliver any service as agreed to in the PCP; or

(c) When funding, laws, regulations, or the CMHP or Department priorities change such that funding is no longer available, redirected to other purposes, or reduced;

(d) The individual's service needs change;

(e) The individual is absent without providing notice to the provider for five or more consecutive days;

(f) The individual is determined to be ineligible for services;

(g) The individual moves, with or without notice, from the Adult Foster Home; the provider will be paid only through the last day of the individual's occupancy.

(2) Department Obligation. The CMHP or Department is under no obligation to maintain the Adult Foster Home at its licensed capacity or to provide payments to potential providers.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 19-1985(Temp), f. & ef. 12-27-85; MHD 6-1986, f. & ef. 7-2-86; MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92), Renumbered from 309-040-0055(3)(a)-(c); MHD 6-1999, f. 8-24-99, cert. ef. 8-26-99; Renumbered from 309-040-0057, MHD 3-2005, f. & cert. ef. 4-1-05

309-040-0455
Enjoinment of Adult Foster Home (AFH) Operation

The Department may commence an action to enjoin (ban) the operation of an Adult Foster Home pursuant to ORS 443.775(5):

(1) Unlicensed. When an Adult Foster Home is operated without a valid license; or

(2) Unresolved Placement. After notice of revocation, nonrenewal, or suspension has been given, a reasonable time for placement of residents in other facilities has been allowed, and such placement has not been accomplished.

Stat. Auth.: ORS 409.010, 409.050
Stats. Implemented: ORS 443.705 - 443.825
Hist.: MHD 1-1992, f. & cert. ef. 1-7-92 (and corrected 1-31-92); Renumbered from 309-040-0099, MHD 3-2005, f. & cert. ef. 4-1-05

DEVELOPMENTAL DISABILITY SERVICES

DIVISION 41

CONTRACT PROGRAMS

Early Intervention Services

309-041-0200
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards for the Mental Health and Developmental Disability Services Division and the Department of Education for the provision of early intervention services to handicapped preschool children with mental retardation or other developmental disabilities, vision impairment, or hearing impairment.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 343.353 to 343.367.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0205
Definitions

As used in these rules:

(1) "Age of Eligibility" is determined based on the child's age on the date established in Oregon law for determining school age for the current year. Children under the age of five are eligible for the program. Children between the ages of five and six are eligible if their resident school district does not provide public education beginning at age five.

(2) "Ancillary Services" means specialized services provided so the child may participate in the appropriate early intervention program. Such services may include but are not limited to physical therapy, occupational therapy, speech therapy, and services by specialists in hearing and vision impairment.

(3) "Classroom Training" means an early intervention program provided in a classroom setting that may include education and training in self-contained programs for the handicapped, parent cooperatives, Head Start programs, or other programs for preschool aged children.

(4) "Community Mental Health Program" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an interagency agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(5) "Developmental Disability (DD)" means for the purposes of this rule a disability of a person which is attributed to mental retardation, cerebral palsy, epilepsy or other handicapping condition and the disability:

(a) Originates before the person attains the age of 22 years, except that in case of mental retardation the condition must be manifested before the age of 18;

(b) Can be expected to continue indefinitely; and

(c) Constitutes a substantial delay in the child's ability to function in society.

(6) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(7) "Early Intervention" means services of treatment and habilitation designed to address a child's developmental deficits in sensory, motor, communication, self-help, and socialization areas. Such services may include classroom training, parent training and consultation, transportation to classroom programs, and other ancillary services, such as physical therapy, occupational therapy, and speech therapy.

(8) "Handicapped Preschool Child" means children between the time of identification of their handicap and school age who meet the eligibility criteria for early intervention services as established under these rules.

(9) "Hearing Impairment" means:

(a) An average of 25 decibels or greater pure tone loss of hearing across three frequencies in the better ear (other than a temporary loss which can be reversed medically);

(b) For children three years old to school age one or more of the following characteristics:

(A) Speech unintelligible to the listener 25 percent of the time for students through age four and 15 percent of the time for students age five to school age;

(B) Oral language delay as determined by appropriate instruments, of one year, for ages three to six.

(10) "Individual Training" means a specific program based on an assessment of a child's need for skill training.

(11) "Individual Program Plan" means a training plan developed annually for each preschool child which contains measurable goals and objectives for the child's developmental growth, and which is developed after consideration of all appropriate assessment information and with full involvement of the child's parent(s), guardian, or representative and professional with specific knowledge related to the child's disability.

(12) "Local Mental Health Authority" means the county court or board of county commissioners of one or more counties who operate a community mental health program, or in the case of a Native American reservation, the tribal council, or if the county declines to operate or contract for all or part of a community mental health program, the board of directors of a public or private corporation.

(13) "Mental Retardation (MR)" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the development period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "**Manual on Terminology and Classification in Mental Retardation**" **of the American Association on Mental Deficiency**, **1977 Revision**. Mental retardation is synonymous with mental deficiency.

(14) "Parent" means a natural parent, guardian, or other primary residential care giver including but not limited to foster parents.

(15) "Parent Training Program" means a training program for the parents of children designed to teach the parents or other primary caregivers, the skills necessary to provide the child with the stimulation and skill level necessary to maximize the child's development.

(16) "Regional Program" means programs contracted by the Oregon Department of Education which provide early intervention and ancillary services to handicapped preschool children with vision impairment and hearing impairment.

(17) "State Agency" means the Mental Health and Developmental Disability Services Division in the case of children with mental retardation or other developmental disabilities, and the Department of Education for children with vision impairment or hearing impairment.

(18) "Vision Impairment" means a condition that exists if one or more of the following exist:

(a) Residual visual acuity is 20/200 or less in the better eye with correction; or

(b) Acuity is 20/70 or less in the better eye with correction; or

(c) Visual field is restricted to 20 degrees; or

(d) Presence of an eye condition, either an eye pathology or a progressive eye disease, which is anticipated to reduce either acuity or field of vision as described above and the child has received or is receiving medical treatment for this condition;

(e) Inadequate functional vision exists as described above and the child is unable to be adequately tested temporarily.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0210
General

(1) Each early intervention program shall be operated by or subcontracted by the community mental health program or a Department of Education regional program.

(2) Community mental health early intervention programs serve children found eligible primarily because of mental retardation or developmental disability. Department of Education regional early intervention programs serve children found eligible primarily because of hearing or vision impairment.

(3) Each early intervention program shall enroll children determined eligible for service without regard to race, color, creed, sex, national origin, or duration of Oregon residence.

(4) Each early intervention program shall develop cooperatively with the community mental health program and the Department of Education regional program serving their areas a written comprehensive plan and agreements to assure the delivery of coordinated early intervention services to all children eligible under this rule. This plan shall:

(a) Be developed within 12 months of the adoption of this rule and modified at least annually thereafter;

(b) Be consistent with the early intervention provisions of ORS 343.353 to 343.367 requiring the coordinated delivery of services;

(c) Assure the provision of state-approved early intervention services to all eligible preschool children within the service area; and

(d) Include at least the following elements:

(A) Evidence that a local early intervention advisory group has been formed in the local area representing both providers and parents of handicapped preschool children;

(B) Designation of which agency or agencies will be the primary providers for early intervention services;

(C) Determination of the array of services needed in the area;

(D) Determination of ancillary services needed in the area;

(E) Description of eligible children in the area, categorized by age, sex, and diagnosis;

(F) Description of how services and funding will be mixed and matched in the most efficient manner across all disability categories;

(G) Description of how programs will assure opportunities for handicapped preschool children to interact with their non-handicapped peers;

(H) Description of agreements between the primary providers and other agencies that assure the provision of needed ancillary services; and

(I) Determination of a "fixed point of referral" for the area that assures a timely evaluation and placement of an eligible child in one or more components of the early intervention program.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0215
Eligibility Determination

(1) The fixed point of referral, established under OAR 309-041-0210(4), shall accept the referral, notify the resident district of a possible eligible child, and assure that a complete evaluation occurs through referral and follow-up to an approved evaluation source.

(2) An approved evaluation source, for the purposes of this rule shall include:

(a) The Crippled Children's Division; or

(b) The Diagnosis and Evaluation section of the Mental Health and Developmental Disability Services Division; or

(c) A multi-disciplinary team from the resident school district or education services district, charged with the identification of handicapped children; or

(d) Other agencies as approved by the Mental Health and Developmental Disability Services Division or the Department of Education; or

(e) Any combination of the above listed sources.

(3) The community mental health program or the appropriate regional program, after making the evaluation material available to the resident school district to review, shall make the determination of eligibility using:

(a) Documentation, from an approved evaluation source, that the referred child has a vision impairment, hearing impairment, mental retardation, or a developmental disability as defined in this rule; and

(b) Documentation from an approved evaluation source that the child's developmental age is:

(A) 56 to 75 percent of the child's chronological age in three or more of the following skill areas:

(i) Gross motor;

(ii) Fine motor;

(iii) Communication;

(iv) Expressive language;

(v) Receptive language;

(vi) Cognitive;

(vii) Self-help; and

(viii) Capacity to relate appropriately to people, objects, or events.

(B) 40 to 55 percent of the child's chronological age in two of the skill areas in paragraph (A) of this subsection; or

(C) Less than 40 percent of the child's chronological age in one of the skill areas in paragraph (A) of this subsection; or

(D) In the case of children below 18 months of age, there is medical documentation that the child has an identified genetic, neurological, muscular, or medical condition that will result in the child being developmentally disabled.

(4) Upon determination of eligibility, the resident school district of the child shall be notified of the determination, and the child shall be enrolled in the appropriate early intervention program.

(5) In areas where Department of Education regional programs are limited, early intervention program under the Mental Health and Developmental Disability Services Division shall serve children eligible for regional program services for early intervention if:

(a) The Mental Health and Developmental Disability Services Division (MHDDSD) program is deemed by all participants in the development of the individual program plan as the most appropriate early intervention program; and

(b) Provisions have been made for the Department of Education regional program to purchase these services from the MHDDSD program at a rate equal to the rate for any other MHDDSD eligible child.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0220
Enrollment

(1) Eligible children will be enrolled in the appropriate early intervention program, based on the handicapping condition of the child, as defined in these rules.

(2) The following information must be on file with the early intervention program:

(a) Copies of evaluation materials used to determine eligibility;

(b) Statement of eligibility from the community mental health program or the appropriate regional program;

(c) Signed statement from the child's parents, guardians, or representative indicating that the purpose of enrollment has been clearly explained, program services have been described, grievance procedures have been explained, and they agree to the child's enrollment in the program;

(d) Documentation that the resident school district of the child has been notified that the enrollment has taken place;

(e) A written statement by a physician licensed by the State of Oregon, California, Washington or Idaho that the child has been examined. The statement shall specify:

(A) Whether there are any physical factors contributing to the individual's skill deficit;

(B) Whether medical treatment is required prior to initiation of early intervention services;

(C) Whether there are any medical limitations to the child's full participation in the early intervention program; and

(D) Whether any other medical examinations are required before initiation of all or any part of the early intervention program.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0225
Individual Program Plans

(1) Within 30 days of enrollment of an eligible child in the program, an individual program plan shall be developed in writing.

(2) To develop the individual program plan, the early intervention program will assess each child using formal assessments, observations, parent interviews, informal assessment procedures, and, if necessary, placement in the program not to exceed 30 days to determine each child's functional level in the areas of gross-motor, fine motor cognition, communication, self-help, and socialization (capacity to relate appropriately to people, objects, or events).

(3) Participants in the development and review of each individual program plan shall include the child's parent(s) or guardian and the child's instructor/parent trainer. For a child's initial individual program plan, an instructor/parent trainer or some other person who is knowledgeable about the assessment procedures used and is familiar with the results shall be present at the meeting. A representative of the resident school district shall be invited to participate and must be represented during the year prior to the child's attaining school age. Others as appropriate shall be involved.

(4) The individual program plan shall include:

(a) A statement of the child's present level of skill performance;

(b) A statement of annual goals, including short-term training objectives;

(c) A statement describing the specific early intervention services to be provided to the child within the appropriate early intervention program;

(d) The projected dates for beginning each service, anticipated frequency of services, and the expected duration of the services;

(e) A description of the training and habilitation methods to be used and objective criteria, procedures, and schedules for evaluating whether the program goals and objectives are being met. This evaluation of program effectiveness must occur at least annually; and

(f) A listing of all parties participating in the individual program plan development.

(5) Each child's individual program plan shall be reviewed at least annually.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0230
Program Requirements

(1) Statement of Purpose: Each early intervention program shall develop and maintain for public review a written statement of purpose, which shall include:

(a) A statement of the program's goals and objectives;

(b) A general statement of the services provided by the program;

(c) A description of parent involvement in the program;

(d) A statement of the program's enrollment criteria; and

(e) A description of the program's policy and procedures to assure coordination with other providers of early intervention services within the same county.

(2) Reporting: Each early intervention program shall provide the following reports to the state agency responsible for the program:

(a) An individual progress assessment for each child, on forms provided by the state agency;

(b) A monthly report documenting the current status of children enrolled or terminated from service;

(c) An annual statement verifying the resident school district of each enrolled child found eligible for the program;

(d) Other reports as may be reasonably required by the state agency.

(3) Furniture and Equipment: An early intervention program shall secure, and maintain in good repair, furniture and other equipment necessary to meet the training needs of each child enrolled.

(4) Instructional Materials: An early intervention program shall secure and maintain age-appropriate and current instructional materials and supplies required for each child enrolled.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0235
Building Requirements

(1) All early intervention programs shall be free of architectural barriers which might prevent use of the facility by handicapped persons.

(2) All early intervention programs shall comply with all local and state fire, health, and safety regulations.

(3) Classroom programs shall provide:

(a) Adequate classroom space for each child in addition to adequate storage capability and outside playground areas;

(b) A restroom adjacent or readily accessible to the classroom; and

(c) Adequate lighting for classroom activities.

(4) Parent training programs shall provide a private area for parents receiving parent training.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0240
Transportation

(1) The school district of residence shall provide transportation services to handicapped preschool children eligible for services under this rule.

(2) Transportation services are required for children only, and are intended to assure services are not denied to any eligible child because of the inaccessibility of the program.

(3) Transportation services may include:

(a) Mileage reimbursement to parents or volunteers;

(b) Direct transportation using school district transportation services;

(c) Contracts for transportation services with private parties or agencies.

(4) Transportation services shall be provide for each eligible child to the most appropriate program, within the county of residence. Transportation to programs across county borders shall be required only when the parent(s), service provider(s), County Mental Health Program, and the resident school district agree that the local approved program cannot meet the eligible child's needs.

(5) Transportation of parents for the purposes of parent training services, is not required under this rule, but may be provided at the discretion of the resident district.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0245
Staffing Requirements

(1) Each early intervention program shall have an affirmative action policy which prohibits discrimination in employment practices.

(2) Each parent training program shall provide at a minimum:

(a) Staff necessary to assure at least one hour per week, 12 months per year, of direct instruction to the child and the parent(s), guardian, or designated primary care giver for each enrolled child; and

(b) Consultation and assessment services in the ancillary services areas as appropriate to the child's needs.

(3) Each parent trainer shall possess a minimum of a Bachelor of Science degree and have specialized training in the area of early childhood development and/or special education.

(4) Each classroom program shall provide at a minimum:

(a) Instructional staff including teaching assistants and aides, necessary to assure a one adult to four children ratio and to provide at least 15 hours per week of individualized instruction in a classroom setting;

(b) Operation for a minimum of 175 days per year;

(c) Consultation and training to parents, guardians, or designated primary care givers of enrolled children, as appropriate; and

(d) Consultation and assessment services in the ancillary services areas as appropriate to the child's needs.

(5) Each preschool classroom teacher shall possess at least a Bachelor of Science degree in early childhood development or special education.

(6) Each early intervention program may provide direct therapy services, in the areas defined as ancillary services in this rule, as appropriate to the individual program plan of a child, and within the limit of funds available to the program.

(7) Each classroom assistant shall receive at least 12 hours of preservice training.

(8) Each person employed to provide ancillary services shall possess the appropriate license or certification necessary to practice in Oregon, or documentation of the completion of recognized specialized training in the area in which they are employed to work.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0250
Grievance Procedures

In cases where parents, guardians, surrogate parents, advocates, program staff, or concerned others have disagreements regarding eligibility, the provision of services required under these rules or other child-centered issues, the following process to resolve these disagreements shall be followed:

(1) All issues should be resolved through the use of internal/local informal procedures when possible to include:

(a) Parent-staff meetings;

(b) Meetings with program administrative staff; and

(c) Local interagency meetings.

(2) When informal procedures cannot resolve the issue, the party(ies) filing the grievance shall request a formal mediation of the disagreement from the community mental from the health program or regional program, as appropriate, using procedures developed by each program.

(3) Local mediation recommendations can be appealed, in cases of disagreements, using the following formal procedure:

(a) The party requesting resolution shall submit in writing a request for formal appeal to the Program Office for Mental Retardation and Developmental Disabilities of the Mental Health and Developmental Disability Services Division or the Division of Special Education of the Department of Education as appropriate;

(b) The agency receiving the request shall:

(A) Schedule a formal appeal meeting to occur within 30 days of the receipt of the request;

(B) Notify in writing each party involved in the disagreement of the date, time, and location of the meeting, allowing at least 15 days from the receipt of meeting notification until the scheduled meeting time;

(C) Appoint an appeal officer to conduct the meeting, using procedures established by the state agency; and

(D) Guarantee that the meeting will be conducted using procedures established by the state agency for such meetings, assure parent and child rights, and afford clear protection for due process procedures.

(c) Within 15 days after the conclusion of the meeting, the appeal officer will provide his recommendations in writing to the appropriate state agency official for implementation;

(d) The appropriate official of the state agency will notify in writing all participants in the appeal meeting of the recommendations and implementation process within 15 days of receipt of the recommendations.

(4) If any party does not agree with the recommendations or implementation process they may appeal to the Administrator of the Mental Health and Developmental Disability Services Division or the Superintendent of Instruction, as appropriate, for review and reconsideration. The decision of the appropriate state agency administrator is final except as it may be appealed through normal judicial procedures:

(a) The appeal must be made in writing within 15 days of the receipt of the recommendations and implementation process; and

(b) The appropriate state agency administrator shall review all relevant testimony, seek clarification as needed, and issue the decision on the appeal to all parties within 30 days of receipt of the appeal.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

309-041-0255
Variances

A variance from these rules may be granted to an early intervention program in the following manner:

(1) An agency requesting a variance shall submit, in writing, through the community mental health program or regional program, to the Mental Health and Developmental Disability Services Division or the Department of Education:

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

(b) The reason for the proposed variance;

(c) The alternative practice proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the local mental health authority or regional services agency and the local early intervention advisory group indicating its support of the proposed variance.

(2) The appropriate state agency shall approve or deny the request for variance.

(3) The state agency shall notify the community mental health program or regional program of the decision. The appropriate community agency will forward the decision and reasons therefor to the program requesting the variance. This notice shall be given the program within 30 days of receipt of the request by the state agency.

(4) Appeal of the denial of a variance request shall be to the Administrator of the appropriate state agency, whose decision shall be final.

(5) A variance granted by the state agency shall be attached to, and become a part of, the contract for that year.

Stat. Auth.: ORS 343 & 430
Stats. Implemented:
Hist.: MHD 6-1985, f. & ef. 4-5-85

Programs for Developmental Disabilities

Supported Living Services for Individuals with Developmental Disabilities

309-041-0550
Statement of Purpose, Mission Statement, and Statutory Authority

(1) Purpose. These rules prescribe standards by which the Mental Health and Developmental Disability Services Division approves programs that provide supported living services for individuals with developmental disabilities.

(2) Mission Statement. The overall mission of the Office of Developmental Disability Services is to provide support services that enhance the quality of life of persons with developmental disabilities.

(a) Supported living services are a key element in the service delivery system and are critical to achieving this mission.

(b) The goal of supported living is to assist individuals to live in their own homes, in their own communities.

(c) The term "Supported Living" refers to a service which provides the opportunity for persons with developmental disabilities to live in the residence of their choice within the community with recognition that needs and preferences may change over time. Levels of support are based upon individual needs and preferences as defined in the Individual Support Plan. Such services may include up to 24 hours per day of paid supports which are provided in a manner that protects individuals' dignity.

(d) The service provider is responsible for developing and implementing policies and procedures and/or plans that ensure that the requirements of this rule are met.

(e) In addition, the service provider must ensure services comply with all applicable local, state and federal laws and regulations.

(f) The purpose of this rule is to ensure that the service provider meets basic management, programmatic, health and safety, and human rights regulations for those individuals receiving supported living services funded by the Mental Health and Developmental Disability Services Division.

(3) Statutory Authority. These rules are authorized by ORS 430.041(1) and carry out the provisions of ORS 430.021(4) and 430.630(2)(c).

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0560
Definitions

As used in these rules, the following definitions apply:

(1) "Abuse of an adult" as defined in OAR 309-040-0200 to 309-040-0290 includes but is not limited to:

(a) Any death caused by other than accidental or natural, or means occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or service provider, or other staff and the adult. Sexual exploitation also includes failure of staff to discourage sexual advances towards staff by individuals served. For situations other than those involving an employee, service provider, or other staff and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical conduct directed toward the adult;

(e) Failure to act/neglect that causes or has significant potential to cause physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to the failure by a service provider or staff to provide an adult with adequate food, clothing, shelter, medical care, supervision, a safe environment or other services or supports necessary to maintain health and well-being, or through condoning or permitting abuse of an adult by any other person. However, no person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment;

(f) Verbal mistreatment by subjecting an adult to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation and threatening injury or withholding of services or supports, including implied or direct threat of termination of services. It is not considered verbal mistreatment, however, in situations where the consequence for non-compliance may result in the termination of services, if agreed upon by the ISP team;

(g) Placing restrictions on an individual's freedom of movement by seclusion in a locked room under any condition, restriction to an area of the residence or from access to ordinarily accessible areas of the residence, unless arranged for and agreed to on the individual's support plan;

(h) Using restraints without written physician's order, or unless an individual's actions present an imminent danger to himself/herself or others, and in such circumstances until other appropriate action is taken by medical, emergency or police personnel or unless arranged for and agreed to on the ISP;

(i) Financial exploitation which may include, but is not limited to: unauthorized rate increases; staff borrowing from or loaning money to individuals; witnessing wills in which the program is beneficiary; and/or adding the program's name to the individual's bank account(s) or other personal property without approval of the individual or his/her legal guardian and notification of the ISP Team; and

(j) Inappropriately expending an individual's personal funds, theft of an individual's personal funds, using an individual's funds for staff's own benefit, comingling an individual's personal funds with program and/or another individual's funds, or the program becoming an individual's guardian or conservator.

(2) "Abuse investigation and protective services" means an investigation as required by OAR 309-040-0240 and any subsequent services or supports necessary to prevent further abuse.

(3) "Administration of medication" means the act of a staff member, who is responsible for the individual's care, of placing a medication in, or on, an individual's body.

(4) "Adult" means a person 18 years or older with developmental disabilities for whom services are planned and provided.

(5) "Advocate" means a person other than staff who has been selected by the individual or by the individual's legal representative to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(6) "Aid to physical functioning" means any special equipment prescribed for an individual by a physician, therapist, or dietician which maintains or enhances the individual's physical functioning.

(7) "Annual ISP meeting" means an annual meeting, coordinated by a case manager of the community mental health program, which is attended by the individual served, agency representatives who provide service to the individual, the guardian, if any, relatives of the individual and/or other persons, such as an advocate, as appropriate. The purpose of the meeting is to determine needs, coordinate services and training, and develop an Individual Support Plan.

(8) "Board of Directors" means a group of individuals formed to set policy and give directions to a program designed to provide residential services for individuals with developmental disabilities. This includes local advisory boards used by multi-state organizations.

(9) "Case manager" means an employee of the community mental health program or other agency which contracts with the County or Division, who is selected to plan, procure, coordinate, monitor individual support plan services and to act as a proponent for persons with developmental disabilities.

(10) "Certificate" means a document issued by the Mental Health and Developmental Disability Services Division to a provider of supported living services which certifies that the provider is eligible to receive State funds for these services.

(11) "Choice" means the individual's expression of preferences of activities and services through verbal, sign language or other communication method.

(12) "Community mental health program" or "CMHP" means the organization of all services for individuals with mental or emotional disturbances, developmental disabilities or chemical dependency, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(13) "Complaint investigation" means an investigation of any allegation which has been made to a proper authority that the service provider has taken an action which is alleged to be contrary to law, rule or policy that is not covered by an abuse investigation or a grievance procedure.

(14) "Controlled substance" means any drug classified as Schedules 1 through 5 under the Federal Controlled Substance Act.

(15) "Developmental disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy and/or other neurological handicapping condition which requires training or support similar to that required by individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18; and

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the person to function in society; or

(d) Results in significant subaverage general intellectual functioning with concurrent deficits in adaptive behavior which are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classification shall be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiencies, 1983 Revision. Mental retardation is synonymous with mental deficiency.

(16) "Director" means the individual responsible for administration of the supported living program and provision of support services for individuals.

(17) "Division" means the Mental Health and Developmental Disability Services Division.

(18) "Entry" means the admission to a Division funded service.

(19) "Exit" means either termination or transfer from one Division funded program to another. Exit from a program does not include transfer within a program.

(20) "Grievance" means a formal complaint by the individual or a person acting on his/her behalf about any aspect of the program or an employee of the program.

(21) "Health Care Provider" means a person licensed, certified or otherwise authorized or permitted by law of this state to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.

(22) "Incident report" means a written report of any injury, accident, acts of physical aggression or unusual incident involving an individual.

(23) "Independence" is defined as the extent to which persons with mental retardation or developmental disabilities, with or without staff assistance, exert control and choice over their own lives.

(24) "Individual" means a person with developmental disabilities for whom services are planned and provided.

(25) "Individual profile" means a written profile that describes the individual entering into supported living. The profile may consist of materials and/or assessments generated by the service provider or other related agencies, consultants, family members, and/or advocates.

(26) "Individual Support Plan" or "ISP" means a written plan of support and training services for an individual covering a 12-month period which addresses the individual's support needs and the service provider's program plan. This written plan of training and support services was formally referred to as Individual Habilitation Plan (IHP).

(27) "Individual Support Plan Team" or "ISP team" means a team composed of the individual, the case manager, the individual's legal guardian, representatives of all current service providers, and advocate or others determined appropriate by the individual receiving services. If the individual is unable to or does not express a preference, other appropriate team membership shall be determined by the ISP team members.

(28) "Integration" (defined in ORS 427.005) means that persons with mental retardation or other developmental disabilities live in the community and use the same community resources that are used by and available to other members of the community; and participate in the same community activities other community members participate in, and have contact with other community members.

(29) "Legal representative" means the parent if the individual is under age 18, unless the court appoints another individual or agency to act as guardian. For those individuals over the age of 18, a legal representative means an attorney at law who has been retained by or for the adult, or a person who is authorized by a court to make decisions about services for the individual.

(30) "Medication" means any drug, chemical, compound, suspension or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any individual.

(31) "Needs meeting" means a process in which the ISP team defines the supports an individual will need to live in his/her own home, and makes a determination as to the feasibility of creating such services. The information generated in this meeting(s) or discussion(s) shall be used by the supported living provider to develop the individual's transition plan.

(32) "Office of Developmental Disability Services" or "DD Office" means the Office of Developmental Disability Services of the Mental Health and Developmental Disability Services Division.

(33) "Personal futures planning" means an optional planning process for describing a desirable future for a person with developmental disabilities. The planning process generally occurs around major life transitions (e.g. moving into a new home, graduation from high school, marriage, etc.). This process helps determine activities, supports and resources which will best create a desirable future for the individual.

(34) "Physical restraint" means restricting the movement of an individual or restricting the movement or normal function of a portion of the individual's body.

(35) "Prescription medication" means any medication that requires a physician prescription before it can be obtained from a pharmacist.

(36) "Protection" means the necessary actions taken to prevent subsequent abuse or exploitation of the individual, to prevent self-destructive acts, and/or to safeguard an individual's person, property and funds as possible.

(37) "Psychotropic medication" is defined as a medication whose prescribed intent is to affect or alter thought processes, mood, or behavior. This includes, but is not limited to, anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. Because a medication may have many different effects, its classification depends upon its stated, intended effect when prescribed.

(38) "Self-administration of medication" means the individual manages and takes his/her own medication. It includes identifying his/her medication and the times and methods of administration, placing the medication internally in or externally on his/her own body without staff assistance, upon written order of a physician, and safely maintaining the medication(s) without supervision.

(39) "Service provider" means a public or private community agency or organization that provides recognized mental health or developmental disability service(s) and is approved by the Division or other appropriate agency to provide these service(s). For the purpose of this rule "provider" or "Program" is synonymous with "service provider."

(40) "Significant other" means a person selected by the individual to be his/her friend.

(41) "Staff" means a paid employee responsible for providing support services to individuals and whose wages are paid in part or in full with funds contracted through the Developmental Disability Services Office.

(42) "Support" means those services that assist an individual maintaining or increaseing his or her functional independence, achieving community presence and participation, enhancing productivity, and enjoying a satisfying lifestyle. Support services can include training, the systematic, planned maintenance, development or enhancement of self-care, social or independent living skills, or the planned sequence

of systematic interactions, activities, structured learning situations, or educational experiences designed to meet each individual's specified needs in the areas of integration and independence.

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

(44) "Transfer" means movement of an individual from one type of service to another administered by the same service provider.

(45) "Transition plan" means a written plan for the period of time between an individual's entry into a particular service and the time when the individual's ISP is developed and approved by the ISP team. The plan shall include a summary of the services necessary to facilitate adjustment to supported living, ensure health and safety, and the assessments and/or consultations necessary for the ISP development.

(46) "Unusual incident" means those incidents involving serious illness or accidents, death of an individual, injury or illness of an individual requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, or any incident requiring an abuse investigation.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430.041(1)

Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0570

Issuance of Certificate

(1) Certificate required. No person or governmental unit acting individually or jointly with any other person or governmental unit shall establish, conduct, maintain, manage or operate a supported living program without being certified.

(2) Not transferable. Each certificate is issued only for the supported living program and persons or governmental units named in the application and shall not be transferable or assignable.

(3) Terms of certificate. Each certificate is issued for a maximum of two years.

(4) Service provider review. As part of the certificated renewal process, the service provider shall conduct a self-evaluation based upon the requirements of this rule.

(a) The service provider shall document the self-evaluation information on forms provided by the DD Office;

(b) The service provider shall develop and implement a plan of improvement based upon the findings of the self-evaluation; and

(c) The service provider shall submit these documents to the local CMHP with a copy to the DD Office.

(5) DD Office review. The DD Office shall conduct a review of the service provider prior to the issuance of a certificate.

Stat. Auth.: ORS 430.041(1)

Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0580

Application for Initial Certificate and Certificate Renewal

(1) Form. The application shall be on a form provided by the Division and shall include all information requested by the Division.

(2) Initial application. The applicant shall identify the number of individuals to be served.

(3) Renewal application. To renew certification, the service provider shall make application at least 30 days but not more than 120 days prior to the expiration date of the existing certificate. On renewal, no increase in the number of individuals to be served shall be certified unless specifically approved by the Division.

(4) Renewal application extends expiration date. Filing of an application for renewal at least 30 days but not more than 120 days prior to the expiration date of the existing certificate extends the effective date until the Division or its designee takes action upon such application.

(5) Incomplete or incorrect information. Failure to disclose requested information on the application or provision of incomplete or incorrect information on the application may result in denial, revocation or refusal to renew the certificate.

(6) Demonstrated capability. Prior to issuance or renewal of the certificate the applicant must demonstrate to the satisfaction of the Division that the applicant is capable of providing services identified in a manner consistent with the requirements of these rules.

(7) Separate certificates. Separate certificates are required when the service provider delivers services in multiple counties to the extent that contracts with each different county are required.

Stat. Auth.: ORS 430.041(1)

Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0590

Certification Expiration, Termination of Operations, Certificate Return

(1) Expiration. Unless revoked, suspended or terminated earlier, each certificate to operate a supported living program shall expire on the expiration date specified on the certificate.

(2) Termination of operation. If a supported living program operation is discontinued, the certificate terminates automatically on the date the operation is discontinued.

(3) Return of certificate. Each certificate in the possession of the program shall be returned to the Division immediately upon suspension, revocation or termination.

Stat. Auth.: ORS 430.041(1)

Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0600

Change of Ownership, Legal Entity, Legal Status, Management Corporation

(1) Notice of pending change in ownership, legal entity, legal status or management corporation. The program shall notify the Division in writing of any pending change in the program's ownership or legal entity, legal status or management corporation.

(2) New certificate required. A new certificate shall be required upon change in a program's ownership/legal entity or legal status. The program shall submit a certificate application at least 30 days prior to change in ownership/legal entity or legal status.

Stat. Auth.: ORS 430.041(1)

Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0610

Inspections and Investigations

(1) Inspections and investigations required. All services covered by this rule shall allow the following types of investigations and inspections:

(a) Quality assurance, certificate renewal and onsite inspections;

(b) Complaint investigations; and

(c) Abuse investigations.

(2) Inspections and investigations by the Division, its designee or proper authority. All inspections and investigations shall be performed by the Division, its designee, or proper authority.

(3) Unannounced. Any inspection or investigation may be unannounced.

(4) Required documentation. All documentation and written reports required by this rule shall be:

(a) Open to inspection and investigation by the Division, its designee or proper authority; and

(b) Submitted to the Division within the time allotted.

(5) Priority of investigation under (1)(c). When abuse is alleged or death of an individual has occurred and a law enforcement agency, or the Division and/or its designee has determined to initiate an investigation, the service provider shall not conduct an internal investigation without prior authorization from the Division. For the purposes of this section, an internal investigation is defined as conducting interviews of the alleged victim, witness, the alleged perpetrator or any other person who may have knowledge of the facts of the abuse allegation or related circumstances; reviewing evidence relevant to the abuse allegation, other than the initial report; or any other actions beyond the initial actions of determining:

(a) If there is reasonable cause to believe that abuse has occurred; or

(b) If the alleged victim is in danger or in need of immediate protective services; or

(c) If there is reason to believe that a crime has been committed; or

(d) What, if any, immediate personnel actions shall be taken.

(6) The Division or its designee shall complete an Abuse Investigation and Protective Services Report according to OAR 309-040-0260(1). The report shall include the findings based upon the abuse investigation. "Inconclusive" means that the matter is not resolved, and the available evidence does not support a final decision that there was reasonable cause to believe that abuse occurred or did not occur. "Not substantiated" means that based on the evidence, it was determined that there is reasonable cause to believe that the alleged incident was not in violation of the definitions of abuse and/or attributable to the person(s) alleged to have engaged in such conduct. "Substantiated" means that based on the evidence there is reasonable cause to believe that conduct in violation of the abuse definitions occurred and such conduct is attributable to the person(s) alleged to have engaged in the conduct.

(7) Upon completion of the abuse investigation by the Division, its designee, or a law enforcement agency, a service provider may conduct an investigation without further Division approval to determine if any other personnel actions are necessary.

(8) Abuse Investigation and Protective Services Report. Upon completion of the investigation report according to OAR 309-040-0260(1), the sections of the report which are public records and not exempt from disclosure under the public records law shall be provided to the appropriate service provider(s). The service provider shall implement the actions necessary within the deadlines listed, to prevent further abuse as stated in the report.

(9) Plan of improvement. A plan of improvement shall be submitted to the CMHP and the Division for any noncompliance found during an inspection under this rule.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0620
Alternative Methods, Variances

(1) Criteria for a variance. Variances may be granted to a service provider if the service provider lacks the resources needed to implement the standards required in this rule, if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules or if there are other extenuating circumstances.

(2) Variance application. The service provider requesting a variance shall submit, in writing, an application to the CMHP which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(3) Community Mental Health Program review. The CMHP shall forward signed documentation to the Division within 30 days of receipt of the request for variance indicating its position on the proposed variance.

(4) Office of Developmental Disability Services review. The Assistant Administrator or designee of the DD Office shall approve or deny the request for a variance.

(5) Notification. The DD Office shall notify the provider and the CMHP of the decision. This notice shall be sent within 30 days of the receipt by the DD Office with a copy to other relevant sections of the Division.

(6) Appeal. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(7) Duration of variance. The duration of the variance shall be determined by the DD Office.

(8) Written approval. The provider may implement a variance only after written approval from the Division.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0630
Health: Medical Services

(1) Confidentiality. All individuals' medical records shall be kept confidential as described in OAR 309-041-0730(1).

(2) Sufficient oversight and guidance. Individuals shall receive sufficient oversight and guidance by the program to ensure that their health and medical needs are adequately addressed.

(3) Written health and medical supports. Written health and medical supports shall be developed as required by the individual's ISP team and integrated into the transition plan or ISP. The plan shall be based on a review or identification of the individual's health and medically related support needs and preferences, and updated annually or as significant changes occur.

(4) Written policies and procedures. The program shall have and implement written policies and procedures which maintain and/or improve the physical health of individuals. Policies and procedures shall address early detection and prevention of infectious disease; emergency medical intervention; treatment and documentation of illness and health care concerns; obtaining, administering, storing and disposing of prescription and non-prescription drugs including self administration; and confidentiality of medical records.

(5) Primary physician or health care provider. The provider shall ensure each individual has a primary physician whom he or she has chosen from among qualified providers.

(6) Secondary physician/clinic. Provisions shall be made for a secondary physician/clinic in the event of an emergency.

(7) Medical evaluation. The program shall ensure that individuals have a medical evaluation by a physician no less often than every two years or as recommended by a physician. Evidence of the evaluation shall be placed in the individual's record and shall address:

(a) Current health status;

(b) Changes in health status;

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

(d) Any remedial and corrective action required and when such actions were taken;

(e) Statement of restrictions on activities due to medical limitations; and

(f) A review of medications, treatments, special diets and therapies prescribed.

(8) Medical profile. Provider, before entry, shall obtain the most complete medical profile available, including:

(a) The results of a physical exam made within 90 days prior to entry;

(b) Findings of a TB test made within two weeks of entry;

(c) Results of any dental evaluation;

(d) A record of immunizations;

(e) Status of Hepatitis B screening;

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

(g) A summary of the individual's medical history including chronic health concerns.

(9) Written physician's order. The provider shall ensure that all medications, treatments, and therapies shall:

(a) Have a written order or copy of the written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, is administered to or self-administered by the individual unless otherwise indicated by the ISP team in the written health and medical support section of the ISP or transition plan.

(b) Be followed per written orders.

(10) PRN/Psychotropic medication prohibited. PRN orders shall not be allowed for psychotropic medication.

(11) Drug regimen. The drug regimen of each individual on prescription medication shall be reviewed and evaluated by a physician or physician designee, no less often than every 180 days unless otherwise indicated by the ISP Team in the written health and medical support section of the ISP or transition plan.

(12) Administering prescribed medications and treatments with assistance. All prescribed medications and treatments shall be self-administered unless contraindicated by the ISP team. For individuals who require assistance in the administration of their own medications, the following shall be required:

(a) That the ISP Team has recommended that the individual be assisted with taking their medication;

(b) That there is a written training program for the self-administration of medication unless contraindicated by the ISP Team; and

(c) That there is a written record of medications and treatments, that document physician's orders are being followed.

(13) Independent in medication administration. For individuals who independently self-administer medications, there shall be a plan

for the periodic monitoring and/or review of medications on each individual's ISP.

(14) Use of prosthetic devices. The program shall assist individuals with the use of prosthetic devices as ordered.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0640
Health: Dietary

(1) Identifying amount of support and guidance. The service provider shall be responsible for identifying the amount of support and guidance required to ensure that individuals are provided access to a nutritionally adequate diet.

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

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

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0650
Health: Physical Environment

(1) Maintained. All floors, walls, ceilings, windows, furniture and fixtures shall be maintained.

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

(3) Kitchen and bathroom. Each residence shall have:

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

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

(4) Adequately heated and ventilated. Each residence shall be adequately heated and ventilated.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented:
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92

309-041-0660
Safety: General

(1) Employing means for protecting health and safety. The service provider shall employ means for protecting individuals health and safety which:

(a) Are not unduly restrictive;

(b) May include risks, but do not inordinately affect an individual's health, safety and welfare; and

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

(2) Written safety supports. Written safety supports shall be developed as required by the individual's ISP team and integrated into the transition plan or ISP. The plan shall:

(a) Be based on a review and identification of the person's safety needs and preferences;

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

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

(3) Policies and procedures related to safety, emergencies and disasters. The program shall have and implement policies and procedures that provide for the safety of individuals and for responses to emergencies and disasters.

(4) Smoke detectors. An operable smoke detector shall be available in each bedroom and in a central location on each floor.

(5) Fire extinguisher. An operable class 2A10BC fire extinguisher shall be easily accessible in each residence.

(6) First aid supplies. First aid supplies should be available in each residence.

(7) Emergency fire procedures. The need for emergency evacuation procedures and documentation thereof shall be assessed and determined by the individual's ISP team.

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

(9) Adaptations required for sensory or physically impaired. The service provider shall provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(10) Square footage requirement for bedrooms. Bedrooms shall meet minimum space requirements (single 60 square feet, double 120 square feet with beds located three feet apart).

(11) Window openings. Sleeping rooms shall have at least one window readily openable from the inside without special tools that provides a clear opening through which the individual can exit.

(12) Availability of emergency information. Emergency telephone numbers shall be available at each individual's residence as follows:

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

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

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0670
Safety: Personnel

(1) Basic personnel policies and procedures. The program shall have in place personnel policies and procedures which address suspension, increased supervision or other appropriate disciplinary employment procedures when a staff member has been identified as an alleged perpetrator in an abuse investigation. The program shall also have in place personnel policies and procedures which address disciplinary and/or termination of employment when the allegation of abuse has been substantiated.

(2) Mandatory abuse reporting personnel policies and procedures. Any employee of a private agency which contracts with a CMHP is required to report incidents of abuse when the employee comes in contact with and has reasonable cause to believe that an individual has suffered abuse or that any person with whom the employee comes in contact, while acting in an official capacity, has abused the individual. Notification of mandatory reporting status shall be made at least annually to all employees on forms provided by the Division. All employees shall be provided with a Division-produced card regarding abuse reporting status and abuse reporting.

(3) Director qualifications. The program shall be operated under the supervision of a Director who has minimum of a bachelor's degree and two years experience, including supervision, in developmental disabilities, social services, mental health or a related field; or six years of experience, including supervision, in the field of developmental disabilities or a social service/mental health field.

(4) Staff qualifications. Any staff who supervise individuals shall be at least 18 years of age and capable of performing the duties of the job as described in a current job description which he/she signed and dated.

(5) Personnel files and qualifications records. The program shall maintain a personnel file for each staff person. In addition, the program shall maintain the following for each staff person in a file available to the Division or its designee for inspection:

(a) Written documentation that references and qualifications were checked;

(b) Written documentation of six hours of pre-service training prior to supervising individuals including mandatory abuse reporting training, training on individual profiles and transition plan or ISP;

(c) Documentation that CPR and first aid certification were obtained from a recognized training agency within three months of employment and are kept current;

(d) Written documentation of 12 hours of job-related in-service training annually;

(e) Written documentation of a criminal record clearance by the Division;

(f) Written documentation of a TB test within two weeks of hire; and

(g) Written documentation of employee notification of mandatory abuse reporter status; and

(h) Written documentation of any substantiated abuse allegations; and

(i) Written documentation of any grievances filed against the staff person and the results of the grievance process, including, if any, disciplinary action.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0680
Safety: Staffing Requirements

(1) On-call staff. The program shall provide responsible persons or agency, on-call and available to individuals by telephone at all times.

(2) General staffing requirements. The program shall provide staff appropriate to the number and needs of individuals served as specified in each individual's support plan.

(3) Contract requirements for support staff ratios. Each program shall meet all requirements for staff ratios as specified by contract requirements.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented:
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92

309-041-0690
Safety: Individual Summary Sheets

Current record. A current record shall be maintained by the program for each individual receiving services. The record shall include:

(1) The individual's name, current address, home phone number, date of entry into the program, date of birth, sex, marital status, social security number, social security beneficiary account number, religious preference, preferred hospital, where applicable the number of the Disability Services Office (DSO) or the Multi-Service Office (MSO) of the Seniors and People with Disabilities Division (SPD), guardianship status; and

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

(a) The individual's legal representative, family, advocate, or other designated contact person;

(b) The individual's preferred physician, secondary physician and/or clinic;

(c) The individual's preferred dentist;

(d) The individual's day program, or employer, if any;

(e) The individual's case manager; and

(f) Other agency representatives providing services to the individual.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0700
Safety: Incident Reports and Emergency Notifications

(1) Incident reports. A written report that describes any injury, accident, act of physical aggression or unusual incident involving an individual shall be placed in the individual's record. Such description shall include:

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

(b) A description of the incident;

(c) Staff response at the time; and

(d) Administrative review and follow-up to be taken to prevent a recurrence of the injury, accident, physical aggression or unusual incident.

(2) Sent to case manager. Copies of all unusual incident (as defined by OAR 309-041-0560(45)) reports shall be sent to the case manager within five working days of the incident.

(3) Immediate notification of allegations of abuse and abuse investigations. The program shall notify the CMHP immediately of an incident or allegation of abuse falling within the scope of 309-041-0560(1)(a) through (d). When an abuse investigation has been initiated, the CMHP shall ensure that either the case manager or the program shall also immediately notify the individual's legal guardian or conservator. The parent, next of kin or other significant person may also be notified unless the individual requests the parent, next of kin or other significant person not be notified about the abuse investigation or protective services, or notification has been specifically prohibited by law.

(4) Immediate notification. In the case of a serious illness, injury or death of an individual, the program shall immediately notify:

(a) The individual's legal guardian or conservator, parent, next of kin, designated contact person and/or other significant person;

(b) The Community Mental Health Program; and

(c) Any other agency responsible for the individual.

(5) Missing person notification. In the case of an individual who is missing beyond the timeframes established by the ISP team, the program shall immediately notify:

(a) The individual's designated contact person;

(b) The individual's guardian, if any, or nearest responsible relative;

(c) The local police department; and

(d) The Community Mental Health Program.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0710
Safety: Vehicles and Drivers

(1) Vehicles operated to transport individuals. Service providers that own or operate vehicles that transport individuals shall:

(a) Maintain the vehicles in safe operating condition;

(b) Comply with Department of Motor Vehicles laws;

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

(d) Carry in vehicles a fire extinguisher and first aid kit.

(2) Drivers. Drivers operating vehicles to transport individuals must meet applicable Department of Motor Vehicles requirements.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0715
Rights: Financial

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

(2) Financial policies and procedures. The program shall have and implement written policies and procedures related to the oversight of the individual's financial resources.

(3) Reimbursement to individual. The program shall reimburse to the individual any funds that are missing due to theft and/or mismanagement on the part of any staff of the program, and/or of any funds within the custody of the program that are missing. Such reimbursement shall be made within 10 working days of the verification that funds are missing.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0720
Rights: General

(1) Abuse prohibited. Any adult as defined at 309-041-0560(4) or any individual as defined at 309-041-0560(23) shall not be abused nor shall abuse be condoned by an employee, staff or volunteer of the program.

(2) Policies and procedures. The program shall have and implement written policies and procedures which protect individual's rights and encourage and assist individuals to understand and exercise these rights. These policies and procedures shall at a minimum provide for:

(a) Assurance that each individual has the same civil and human rights accorded to other citizens;

(b) Adequate food, housing, clothing, medical and health care, supportive services and training;

(c) Visits to and from family members, friends, advocates, and when necessary legal and medical professionals;

(d) Private communication, including personal mail and telephone;

(e) Personal property and fostering of personal control and freedom regarding that property;

(f) Privacy;

(g) Protection from abuse and neglect, including freedom from unauthorized training, treatment and chemical/mechanical restraints;

(h) Freedom from unauthorized personal restraints;

(i) Freedom to choose whether or not to participate in religious activity;

(j) The opportunity to vote and training in the voting process if desired;

(k) Expression of sexuality, to marry and to have children;

(l) Access to community resources, including recreation, agency services, employment and alternatives to employment programs, educational opportunities and health care resources;

(m) Transfer of individuals within a program;

(n) Individual choice that allows control and ownership of their personal affairs;

(o) Appropriate services which promote independence, dignity and self-esteem and are also appropriate to the age and preferences of the individual;

(p) Individual choice to consent to or refuse treatment; and

(q) Individual choice to participate in community activities.

(3) Notification of policies and procedures. The program shall inform each individual and parent/guardian/advocate orally and in writing of its rights policy and procedures and a description of how to exercise them at entry to the program and, in a timely manner, as changes occur.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0730
Rights: Confidentiality of Records

Confidentiality. All individuals' records are confidential except as otherwise provided by applicable rule or laws.

(1) For the purpose of disclosure from individual medical records under these rules, service providers under these rules shall be considered "providers" as defined in ORS 179.505(1), and all of ORS 179.505 shall be applicable.

(2) For the purposes of disclosure from nonmedical individual records, all or portions of the information contained in these records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502(2).

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0740
Rights: Grievances

(1) Policies and procedures. The program shall implement written policies and procedures for individuals' grievances. These policies and procedures shall, at a minimum, provide for:

(a) Receipt of grievances from individual(s) or others acting on his/her behalf. If the grievance is associated in any way with abuse or the violation of the individual's rights, the recipient of the grievance shall immediately report the issue to the program's director or designee and the CMHP;

(b) Investigation of the facts supporting or disproving the grievance;

(c) Taking appropriate actions on grievances within five working days following receipt of the grievance;

(d) Submission to the program's director. If the grievance is not resolved it shall be submitted to the program's director for review. Such review shall be completed and a written response provided within 15 days;

(e) Submission to the Community Mental Health Program. If the grievance is not resolved by the program's director it shall be submitted to the Community Mental Health Program for review. Such review shall be completed and a written response provided within 30 days;

(f) Submission to the Administrator. If the grievance is not resolved by the Community Mental Health Program, it may be submitted to the Administrator for review. Such review shall be completed and a written response provided within 45 days of submission. The decision of the Administrator or designee shall be final; and

(g) Documentation of each grievance and its resolution in the grievant's record. If a grievance resulted in disciplinary action against a staff member, the documentation shall include a statement that disciplinary action was taken.

(2) Copies of all grievances to case manager. Copies of the documentation on all grievances shall be sent by the program to the case manager within 15 working days of initial receipt of the grievance.

(3) Notification of policy and procedures. The program shall inform each individual and parent/guardian/advocate orally and in writing at entry to the program and as changes occur in the program's grievance policy and procedures and a description of how to utilize them.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0750
Rights: Personalized Plans

(1) Team process. The decision to support an individual so that he/she can live in and maintain his/her own home requires significant involvement from the individual and his/her ISP team. In supported living, this process is characterized by a series of team meetings or discussions to determine what personalized supports the individual will need to live in his/her home, a determination as to the feasibility of creating such supports, and the development of a written plan which describes services the individual will receive upon entry into supported living.

(2) Needs meeting. Prior to moving into his/her own home, the ISP team shall meet to discuss the individual's projected service needs in a needs meeting. This meeting shall:

(a) Review information related to the individual's health and medical, safety, dietary, financial, social, leisure, staff, mental health and behavioral support needs and preferences;

(b) Include any potential providers, the individual and other ISP team members;

(c) Result in a written list of supports and services needed; and

(d) Discuss the selection of potential providers based on list of support and services needed.

(3) Transition plan. The provider will be required to spend time getting to know the individual personally before working on the development of the transition plan. The individual, provider, and other ISP team members shall participate in an entry meeting prior to the initiation of services. The outcome of this meeting shall be a written transition plan which shall take effect upon entry and shall:

(a) Address the individual's health and medical, safety, dietary, financial, staffing, mental health and behavioral support needs and preferences as required by the ISP team;

(b) Indicate who is responsible for providing the supports described in the plan;

(c) Be based on the list of supports identified in the needs meeting and other assessments and/or consultation required by the ISP team; and

(d) Be in effect and available at the site until the ISP is developed and approved by the ISP team.

(4) Individual support team membership. The team shall include the individual, the case manager, the individual's legal guardian, representatives of all current service providers, the provider who will provide supported living services, and advocate or others determined appropriate by the individual receiving services.

(5) Individual support plan. A copy of each individual's Individual Support Plan shall be developed and approved by the ISP team within 90 days of entry and shall be available at the individual's home within 30 days of development and approval. The plan shall:

(a) Be based on a review and identification of the individual's service needs and preferences;

(b) Include a summary of the services related to the individual's health and medical, safety, dietary, financial and mental health and behavioral needs and preferences as determined by the ISP team;

(c) Identify who is responsible for providing the services and supports described in the plan; and

(d) Be updated as significant changes occur and/or at least annually.

(6) Distribution of ISP document. The case manager shall ensure distribution of a copy of the ISP to all team members within 30 calendar days of the ISP team meeting.

(7) Individual Profile. The program shall develop a written profile which describes the individual. This information shall be used in training new staff. The profile shall be completed within 90 days of entry. The profile shall include information related to the individual's history or personal highlights, lifestyle and activity choices and preferences, social network/significant relationships, and other information that helps describe the individual.

(8) Profile composition. The profile shall be composed of written information generated by the program. It may include reports of assessments or consultations; historical or current materials developed by the CMHP, training centers, and/or nursing homes; material/pictures from the family and/or advocates; newspaper articles; and other relevant information.

(9) Profile maintained. The profile shall be maintained at the service site and updated as significant changes occur.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0760
Rights: Behavior Intervention

(1) Written policy. The service provider shall have and implement a written policy concerning behavior intervention procedures. The service provider shall inform the individual and his/her legal guardian of the behavior intervention policy and procedures at the time of entry and as changes occur.

(2) Implementation of a program to alter an individual's behavior. A decision to implement a program to alter an individual's behavior shall be made by the ISP team and the program shall be described fully in the individual's ISP. The program shall:

(a) Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention;

(b) Use the least intervention possible;

(c) Ensure that abusive or demeaning intervention shall never be used; and

(d) Be evaluated by the service provider through timely review of specific data on the progress and effectiveness of the procedure.

(3) Documentation requirements. Documentation regarding the behavior program shall include:

(a) Documentation that the individual, the guardian, and ISP team are fully aware of and consent to the program in accordance with the ISP process as defined in the Case Management Services Rule OAR 309-041-0420;

(b) Documentation of all prior programs used to develop an alternative behavior; and

(c) A functional analysis of the behavior which has been completed prior to developing the behavior program by a trained staff member and/or consultant. This written record shall include:

(A) A clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;

(B) A clear description of the need to alter the behavior;

(C) An assessment of the meaning of the behavior, which includes the possibility that the behavior is:

(i) An effort to communicate;

(ii) The result of medical conditions;

(iii) The result of environmental causes; or

(iv) The result of other factors;

(d) A description of the conditions which precede the behavior in question;

(e) A description of what appears to reinforce and maintain the behavior; and

(f) A clear and measurable procedure which will be used to alter the behavior and develop the functional alternative behavior.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0770
Rights: Physical Restraints

(1) Circumstances when physical restraint allowed. The service provider shall only employ physical restraint:

(a) As part of an Individual Support Plan that meets 309-041-0760 of this rule;

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

(c) As a health-related protection prescribed by a physician, but only if necessary for individual protection during the time that a medical condition exists.

(2) Staff training. Staff members who need to apply restraint as part of an individual's ongoing training program shall be trained by a Division approved trainer. Documentation verifying such training shall be maintained in his/her personnel file.

(3) Physical restraints in emergency situations. Physical restraints in emergency situations shall:

(a) Be only used until the individual is no longer a threat to self or others;

(b) Be authorized by the program's director or designee, or physician;

(c) Be authorized within one hour of application of restraint;

(d) Result in the immediate notification of the individual's case manager or CMHP designee; and

(e) Prompt an ISP meeting, initiated by the service provider, if used more than three times in a six month period.

(4) Avoid physical injury. Physical restraint shall be designed to avoid physical injury to the individual or others, and to minimize physical and psychological discomfort.

(5) Incident report. All use of physical restraint shall be documented in an incident report. The report shall include:

(a) The name of the individual to whom the restraint is applied;

(b) The date, type and length of time, of restraint application;

(c) The name and position of the person authorizing the use of the restraint;

(d) The name of the staff member(s) applying the restraint; and

(e) Description of the incident.

(6) Copy to CMHP. A copy of the incident report shall be forwarded within five working days of the incident to the Community Mental Health Program.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0780
Rights: Psychotropic Medications and Medications for Behavior

(1) Requirements. Psychotropic medications and medications for behavior shall be:

(a) Prescribed by physician through a written order; and

(b) Included on the individual's ISP.

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

(3) Monitoring and review. Psychotropic medications and medications for behavior shall be:

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

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

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0790
Entry, Exit and Transfer: General

(1) Qualifications for Division funding. All individuals considered for Division-funded services shall:

(a) Be referred by the Community Mental Health Program;

(b) Be determined to have a developmental disability by the Division or its designee; and

(c) Not be discriminated against because of race, color, creed, age, disability, national origin, gender, religion, duration of Oregon residence, method of payment or other forms of discrimination under applicable state or Federal law.

(2) Information required for entry meeting. The program shall acquire the following information prior to an entry ISP meeting:

(a) Written documentation that the individual has been determined to have a developmental disability;

(b) A statement indicating the individual's safety skills including ability to evacuate from a building when warned by a signal device and adjusting water temperature;

(c) A brief written history of any medical conditions or behavioral challenges;

(d) Information related to the individual's lifestyle, activities, and other choices and preferences;

(e) Documentation of the individual's financial resources;

(f) Documentation from a physician of the individual's current physical condition, including a written record of any current or recommended medications, treatments, diet and aids to physical functioning;

(g) Documentation of any guardian or conservator, or any other legal restriction on the rights of the individual, if applicable; and

(h) A copy of the most recent ISP, if applicable.

(3) Entry meeting. An entry ISP team meeting shall be conducted prior to the initiation of services to the individual. The findings of the entry meeting shall be recorded in the individual's file and include at a minimum:

(a) The name of the individual proposed for service;

(b) The date of the meeting;

(c) The date determined to be the date of entry;

(d) Documentation of the participants at the meeting;

(e) Documentation of the pre-entry information required by OAR 309-041-0790(2)(a)–(h);

(f) Documentation of the decision to serve or not serve the individual requesting service, with reasons; and

(g) Documentation of the proposed transition plan as defined in the Case Management Services Rule OAR 309-041-0405(42) for services to be provided if the decision was made to serve.

(4) Exit meeting. Each individual considered for exit shall have a meeting by the ISP team before any decision to exit is made. Findings of such a meeting shall be recorded in the individual's file and include at a minimum:

(a) The name of the individual considered for exit;

(b) The date of the meeting;

(c) Documentation of the participants included in the meeting;

(d) Documentation of the circumstances leading to the proposed exit;

(e) Documentation of the discussion of the strategies to prevent an exit from services (unless the individual is requesting exit);

(f) Documentation of the decision regarding exit including verification of a majority agreement of the meeting participants regarding the decision; and

(g) Documentation of the proposed plan for services for the individual after the exit.

(5) Requirements for waiver of exit meeting. Requirements for an exit meeting may be waived if an individual is immediately removed from the program under the following conditions:

(a) The individual and his/her guardian requests an immediate removal from the program; or

(b) The individual is removed by a legal authority acting pursuant to civil or criminal proceedings.

(6) Transfer meeting. A decision to transfer an individual within a service provider shall be made by the ISP team. Findings of the ISP team shall be recorded in the individual's file and include at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the meeting or telephone call(s);

(c) Documentation of the participants included in the meeting or telephone call(s);

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternative considered, including transfer;

(f) Documentation of the reasons why any preferences of the individual, legal representative and/or family members cannot be honored;

(g) Documentation of a majority agreement of the participants regarding the decision; and

(h) The written plan for services to the individual after transfer.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0800
Rights: Entry, Exit and Transfer: Appeal Process

(1) Procedures. In cases where the individual and parent/guardian/advocate object to or the ISP team cannot reach majority agreement regarding an admission refusal, a request to exit the program, or a transfer within a program, an appeal may be filed by any member of the ISP team.

(a) In the case of a refusal to admit, the slot shall be held vacant but the payment for the slot shall continue.

(b) In the case of request to exit or transfer, the individual shall continue to receive the same services received prior to the appeal until the appeal is resolved.

(2) Appeal to the County. All appeals must be made in writing to the Community Mental Health Program Director or his/her designee for decision using the county's appeal process. The Community Mental Health Program Director or designee shall make a decision within 30 working days of receipt of the appeal and notify the appellant of the decision in writing.

(3) Appeal to Mental Health and Developmental Disability Services Division. The decision of the Community Mental Health Director may be appealed by the individual, his/her parent, guardian, advocate or the provider by notifying the Office of Developmental Disability Services in writing within ten working days of receipt of the county's decision.

(a) A committee shall be appointed by the Administrator or the Administrator's designee in the Office of Developmental Disability Services every two years and shall be composed of a Division representative, a residential service representative and a DD case management representative;

(b) In case of a conflict of interest, as determined by the Administrator or designee, alternative representatives will be temporarily appointed by the Administrator or designee to the committee;

(c) The committee will review the appealed decision and make a written recommendation to the Administrator or designee within 45 working days of receipt of the notice of appeal;

(d) The Administrator or designee shall make a decision on the appeal within ten working days after receipt of the recommendation from the committee; and

(e) If the decision is for admission or continued placement and the provider refuses admission or continued placement, the funding for the slot may be withdrawn by the contractor.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0805
Individual/Family Involvement

Policy needed. The program shall have a policy that addresses:

(1) Opportunities for the individual to participate in decision regarding the operation of the program;

(2) Opportunities for families, guardians, and/or significant others of the individuals served by the program to interact; or

(3) Opportunities for individuals, families, guardians, and significant others to participate on the Board or on committees of the program or to review policies of the program that directly affect the individuals served by the program.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0810
Program Management

(1) Non-discrimination. The program shall comply with all applicable state and federal statutes, rules and regulations in regard to non-discrimination in employment practices.

(2) Prohibition against retaliation. A community program or service provider shall not retaliate against any staff who reports in good faith suspected abuse or retaliate against the adult with respect to any report. An alleged perpetrator cannot self-report solely for the purpose of claiming retaliation.

(a) Subject to penalty. Any community facility, community program or person that retaliates against any person because of a report of suspected abuse or neglect shall be liable according to ORS 430.755, in a private action to that person for actual damages and, in addition, shall be subject to a penalty up to $1000, notwithstanding any other remedy provided by law.

(b) Adverse action defined. Any adverse action is evidence of retaliation if taken within 90 days of a report of abuse. Adverse action means only those actions arising solely from the filing of an abuse report. For purposes of this subsection, "adverse action" means any action taken by a community facility, community program or person involved in a report against the person making the report or against the adult because of the report and includes but is not limited to:

(A) Discharge or transfer from the community program, except for clinical reasons;

(B) Discharge from or termination of employment;

(C) Demotion or reduction in remuneration for services; or

(D) Restriction or prohibition of access to the community program or the resident(s) served by the program.

(3) Documentation requirements. All entries required by this rule, unless stated otherwise, shall:

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

(b) Be accurate and contain no willful falsifications;

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

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

(4) Dissolution of program. Prior to the dissolution of a program, a representative of the governing body or owner shall notify the Division 30 days in advance in writing and make appropriate arrangements for the transfer of individuals' records.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0820
Certificate Denial, Suspension, Revocation, Refusal to Renew

(1) Conditions. The Division may deny, revoke or refuse to renew a certificate when it finds the program, the program's director, or any person holding five percent or greater financial interest in the program:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized and fails to correct the noncompliance within 30 calendar days of receipt of written notice of non-compliance; or

(b) Has demonstrated a substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized during two inspections within a six year period (for the purpose of this subsection, "inspection" means an on-site review of the service site by the Division for the purpose of investigation or certification); or

(c) Has demonstrated a failure to comply with applicable laws relating to safety from fire; or

(d) Has been convicted of a felony; or

(e) Has been convicted of a misdemeanor associated with the operation of a residential program; or

(f) Falsifies information required by the Division to be maintained or submitted regarding care of individuals, supported living program finances or individuals' funds; or

(g) Has been found to have permitted, aided or abetted any illegal act which has had significant adverse impact on individual health, safety or welfare.

(2) Immediate suspension of certificate. In any case where the Division finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Division may, by written notice to the certificate holder, immediately suspend a certificate without a pre-suspension hearing and the service may not continue operation.

(3) Notice of certificate revocation or denial. Following a Division finding that there is a substantial failure to comply with these rules such that the health, safety or welfare of individual is jeopardized, or that one or more of the events listed in section (1) of this rule has occurred, the Division may issue a notice of certificate revocation, denial or refusal to renew.

(4) Informal process. Following the notice issued pursuant to section (3) of this rule, the Division shall provide the certificate holder an opportunity for an informal conference within 10 calendar days from the date of the notice.

(5) Hearing. Following issuance of a notice of certificate revocation, denial or refusal to renew, the Division shall provide the opportunity for a hearing pursuant to OAR 309-041-0830.

Stat. Auth.: ORS 430.041(1)
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

309-041-0830
Hearings

(1) Hearings rights. An applicant for a certificate, or certificate holder, upon written notice from the Division of denial, suspension, revocation or refusal to renew a certificate, may request a hearing pursuant to the Contested Case Provisions of ORS Chapter 183.

(2) Request for hearing. Upon written notification by the Division of revocation, denial or refusal to renew a certificate, pursuant to OAR 309-041-0830(1), the applicant/certified program shall be entitled to a hearing in accordance with ORS Chapter 183 within 60 days of receipt of notice. The request for a hearing shall include an admission or denial of each factual matter alleged by the Division and shall affirmatively allege a short plain statement of each relevant, affirmative defense the applicant/certified program may have.

(3) Hearing rights under OAR 309-041-0820(2). In the event of a suspension pursuant to OAR 309-041-0820(2) and during the first 30 days after the suspension of a certificate, the certified program shall be entitled to a fair hearing within 10 days after its written request to the Division for a hearing regarding certificate suspension. Any hearing requested after the end of the 30 days period following certificate suspension shall be treated as a request for hearing under OAR 309-041-0830(2).

(4) Issue at hearing on denial or revocation pursuant to OAR 309-041-0820(1)(a). The issue at a hearing on certification, denial, revocation, suspension or refusal to renew a certificate pursuant to OAR 309-041-0820(1)(a) is limited to whether the program was/is in compliance at the end of the 30 calendar days following written notice of non-compliance.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.021(4) & 430.630(2)(c)
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97

Service Wait Lists for Persons with Developmental Disabilities

309-041-1190
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for the maintenance of service wait lists for persons with developmental disabilities.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 427.007 and 430.640.

Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 8-1992, f. & cert. ef. 11-16-92

309-041-1200
Definitions

As used in these rules the following definitions apply:

(1) "Case Manager" means an employee of the community mental health program or other agency which contracts with the County or Division, who is selected to plan, procure, coordinate, and monitor individual support plan services and who acts as a proponent for persons with developmental disabilities.

(2) "Community Mental Health Program" or "CMHP" means the organization of all services for individuals with mental or emotional disturbances, developmental disabilities or chemical dependency, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(3) "Comprehensive Services" means 24-hour residential care, including care provided in a group home, supported living, or foster care. Comprehensive services also include intensive in-home supports that exceed $20,000 per year. Intensive supports may include in-home shift care, respite care, employment and other day program supports, community inclusion activities, environmental adaptations, or other services needed to support an individual with complex needs.

(4) "Developmental Disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy or other neurological handicapping condition which requires training or support similar to that required by individuals with mental retardation and the disability:

(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18; and

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the person to function in society; or

(d) Results in significant subaverage general intellectual functioning with concurrent deficits in adaptive behavior which are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **Manual of Terminology and Classification in Mental Retardation by the American Association on Mental Deficiency, 1983 Revision.** Mental retardation is synonymous with mental deficiency.

(5) "Division" means the Mental Health and Developmental Disability Services Division.

(6) "Individual" means a person with developmental disabilities for whom services are planned and needed or provided.

(7) "Individual Support Plan Team" or "ISP Team" means a team composed of the individual, the case manager, the individual's legal guardian, representatives of all current service providers, advocate or other determined appropriate by the individual receiving services. If the individual is unable or does not express a preference, other appropriate team membership shall be determined by the ISP team.

(8) "Office of Development Disability Services" or "ODDS" means the Office of Developmental Disability Services of the Mental Health and Developmental Disability Services Division.

(9) "Private Pay Status" means those individuals who are buying vocational/residential service(s) while waiting for a state funded service.

(10) "Support" means those ancillary services other than direct training which may include, but are not limited to, assisting an individual to maintain skill competencies, achieve community access and social integration, enhance productivity, increase independent functioning and enjoy a satisfying lifestyle.

[Publication: Publications referenced are available from the agency.]

Stat. Auth.: ORS 427 & 430

Stats. Implemented: ORS 427.007 & 430.640

Hist.: MHD 8-1992, f. & cert. ef. 11-16-92; MHD 8-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 3-2002, f. 2-26-02, cert. ef. 2-27-02

309-041-1210

Maintenance of a Centralized Wait List(s) for Individuals Waiting for Services

(1) Eligibility. Individuals must be age 15 or older and must be formally determined eligible for developmental disability case management services to be placed on the county wait list. Individuals in private pay status are eligible for the wait list if they meet these criteria.

(2) Assessment. A written needs and wants assessment will be completed for each individual prior to the placement of the individual's name on the wait list. Such needs assessment will be updated annually thereafter until the individual's name has been removed from the wait list.

(3) Required Data. At a minimum the following information shall be maintained for each individual placed on the wait list:

(a) Name of the individual, current address, and phone number;

(b) Date of birth;

(c) Type of support; i.e., residential, vocational, and/or other support;

(d) Urgency of support need; i.e., how soon will the support be needed;

(e) Level of support; i.e., the degree of support needed; and

(f) Date placed on the wait list. (Private pay status does not affect this date.)

(4) Reporting. The CMHP Developmental Disability Case Management Service will report to the Division individual wait list information at the time the individual is accepted to the county wait list. The Division will provide a format to the CMHP for reporting the required information. Such information will be reviewed annually by the CMHP and any changes in status will be reported to the Division. Terminations from the wait list will be reported when the termination occurs.

Stat. Auth.: ORS 427 & 430

Stats. Implemented:

Hist.: MHD 8-1992, f. & cert. ef. 11-16-92

309-041-1220

Criteria for Selection from Wait List

(1) Selection Factors. When a vacancy in an existing service occurs or a new service is developed, the following factors will be considered in assigning an individual to a vacancy:

(a) Date of entry on the wait list;

(b) Appropriateness of available service to individual need;

(c) Urgency of need; and

(d) The individual's preferences.

(2) Order of Selection. Generally, the individual who has been on the wait list the longest will be assigned to the first service vacancy which arises that is appropriate to that individual's needs. This selection order is subject to the following exceptions:

(a) An individual in crisis having no vocational service and needing such service to resolve the crisis may be given first consideration for an appropriate vocational vacancy regardless of date of entry on the wait list;

(b) An individual in crisis having no residential service and needing such service to resolve the crisis may be given first consideration for an appropriate residential vacancy regardless of date of entry on the wait list; and

(c) No fewer than 300 adult individuals will be selected for entry into non-crisis comprehensive services pursuant to the Staley v Kitzhaber (USDC CV00-0078-ST) settlement agreement during the period July 1, 2001, through June 30, 2009.

(A) The number of individuals receiving non-crisis comprehensive services must be no fewer than the following: 20 individuals by June 30, 2003; 40 individuals by June 30, 2005; 170 individuals by June 30, 2007; 300 individuals by June 30, 2009.

(B) Individuals receiving non-crisis comprehensive services must be adults, 18 years of age or older; must be enrolled in case management; must be eligible for Oregon's Medicaid Waiver for Comprehensive Services; must not at the time of selection be authorized to receive Crisis services as defined in OAR 411-320-0160(7); and individuals and their legal representatives must be ready to accept and move into the developed services within the time frames established and published by the Department.

(C) Priority consideration must be given to individuals previously identified for non-crisis comprehensive services but whose plans were developed during the previous biennium but not completed.

(D) Local Criteria. When Community Developmental Disability Program resources are insufficient to serve all otherwise eligible individuals in the area of service, additional considerations for determining individual selection may be established by Community Developmental Disability Programs under these conditions:

(i) Increasing local capacity must be a local criteria consideration; and

(ii) Local criteria for selection must reflect local needs and resources including the identified needs of the individuals in the service area, the development budget available, the resource opportunities available and the number of individuals requesting services; and

(iii) Established local criteria must be applied consistently across all otherwise qualified individuals in the service area.

(iv) When individuals under consideration for non-crisis comprehensive services meet the criteria established in paragraphs (2)(c)(B) and (C) **and** have comparable needs **and** are equally appropriate for those services, priority will be given to the individual currently living in the family home.

Stat. Auth.: ORS 409.050 & ORS 410.070

Stats. Implemented: ORS 427.007 & 430.640

Hist.: MHD 8-1992, f. & cert. ef. 11-16-92; MHD 8-2001(Temp) f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 3-2002, f. 2-26-02, cert. ef. 2-27-02; MHD 2-2006, f. 6-28-06, cert. ef. 7-1-06

309-041-1230

Wait List Referrals from Other Counties

(1) Referral Process. Services for an individual may be requested of other counties by the Developmental Disability case manager initially by phone. If the referral appears to be feasible the case manager will submit a complete written referral packet including the latest needs assessment to the other county.

(2) Wait List Entry. The wait list status of an individual may be reported to the state only by the county of residence of the individual. A wait list referral to another county will not be entered on the state wait list report for that county but rather will be maintained by the

county of residence. The county receiving the referral may add the individual's name to the county's internal wait list.

Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 8-1992, f. & cert. ef. 11-16-92

309-041-1240
Grievance Procedures

Mediation of grievances. Individuals, legal representatives, family members or advocates may mediate eligibility for, or appropriateness of, services in individual cases per the "Case Management Services for Individuals with Developmental Disabilities and Their Families" rule. (OAR 309-041-0465).

Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 8-1992, f. & cert. ef. 11-16-92

309-041-1250
Variances

(1) Criteria for a variance. Variances may be granted to a CMHP if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts, or procedures would result in services or systems that meet or exceed the standards in this rule.

(2) Variance Application. The CMHP requesting a variance shall submit, in writing, an application to the Division which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A plan and timetable for compliance with the section of the rule from which a variance is sought; and

(e) Signed documentation from the CMHP reflecting the justification for the proposed variance.

(3) Office of Developmental Disability Services Review. The assistant Administrator or designee of the Office of Developmental Disability Services shall approve or deny the request for a variance.

(4) Notification. The ODDS shall notify the CMHP within 30 days of the receipt of the request by the DD Office with a copy to other relevant sections of the Division.

(5) Appeal Application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written Approval. The CMHP may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes terms in that agreement.

Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 8-1992, f. & cert. ef. 11-16-92

Individual Support Plan for Individuals with Developmental Disabilities

309-041-1300
Statement of Purpose, Mission Statement and Statutory Authority

(1) Purpose. These rules prescribe standards for the development and implementation of an Individual Support Plan for individuals with developmental disabilities.

(2) Mission statement. The overall mission of the State of Oregon Mental Health and Developmental Disability Services Division, Office of Developmental Disability Services, is to provide support services that will enhance the quality of life of persons with developmental disabilities.

(a) While the service system reflects the value of family member(s) participation in the ISP process, the Division also recognizes the rights of adults to make informed choices about the level of participation by family members. It is the intent of this rule to fully support the provision of education about personal control and decision-making to individuals who are receiving services.

(b) The ISP process is critical in determining the individual's and the family's preferences for services and supports. The preferences of the individual and family shall serve to guide the team. The individual's active participation and input shall be facilitated throughout the planning process.

(c) The ISP process is designed to identify the types of services and supports necessary to achieve the individual's and family's preferences, identify the barriers to providing those preferred services and develop strategies for reducing the barriers.

(d) The ISP process should also identify strategies to assist the individual in the exercise of his or her rights. This may create tensions between the freedom of choice and interventions necessary to protect the individual from harm. The ISP team must carefully nurture the individual's exercise of rights while being equally sensitive to protecting the individual's health and safety.

(e) The ISP team assigns responsibility for obtaining or providing services to meet those needs.

(3) Statutory authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 430.610 to 430.670 and 427.005 to 427.007.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1310
Definitions

As used in these rules:

(1) "Abuse investigation and protective services" means an investigation as required by OAR 309-040-0240 and any subsequent services or supports necessary to prevent further abuse.

(2) "Abuse of an Adult" means:

(a) Any death caused by other than accidental or natural means, or occurring in unusual circumstances;

(b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

(c) Willful infliction of physical pain or injury;

(d) Sexual harassment or exploitation including, but not limited to, any sexual contact between an employee of a community facility or community program, or service provider or other staff and the adult. Sexual exploitation also includes failure of staff to discourage sexual advances towards staff by adults served. For situations other than those involving an employee, service provider, or other staff and an adult, sexual harassment or exploitation means unwelcome verbal or physical sexual contact including requests for sexual favors and other verbal or physical behavior directed toward the adult;

(e) Failure to act/neglect that leads to or is in imminent danger of causing physical injury, through negligent omission, treatment, or maltreatment of an adult, including but not limited to the failure of a service provider or staff to provide an adult with adequate food, clothing, shelter, medical care, supervision, or through condoning or permitting abuse of an adult by any other person. However, no person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment through prayer alone in lieu of medical treatment;

(f) Verbal mistreatment by subjecting an adult to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion or intimidation and threatening injury or withholding of services or supports. However, it is not considered verbal mistreatment in situations where the consequences of non-compliance may result in termination of services if agreed upon by the ISP team, including implied or direct threat of termination of services;

(g) Placing restrictions on an individual's freedom of movement by seclusion in a locked room under any condition, restriction to an area of the residence or from access to ordinarily accessible areas of the residence, unless arranged for and agreed to on the Individual's Support Plan;

(h) Using restraints without written physician's order, or unless an individual's actions present an imminent danger to himself/herself or others and in such circumstances only until other appropriate action is taken by medical, emergency or police personnel or unless arranged for and agreed to on the ISP;

(i) Financial exploitation which may include, but is not limited to, unauthorized rate increases, staff borrowing from or loaning money to individuals, witnessing wills in which the program is beneficiary, adding program's name to individual's bank accounts or other personal property without approval of the individual, his/her legal guardian, and the ISP team; and

(j) Inappropriately expending the individual's personal funds, theft of an individual's personal funds, using an individual's personal

funds for staff's own benefit, commingling the individual's funds with program and/or other individuals' funds, or the program becoming guardian or conservator.

(3) "Adult" means an individual 18 years or older with developmental disabilities for whom services are planned and provided.

(4) "Advocate" means a person other than paid staff who has been selected by the individual or by the individual's legal representative to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(5) "Annual ISP Meeting" means an annual meeting which is attended by the individual served, agency representatives who provide service to the individual, case manager, the guardian, if any, relatives of the individual and/or other persons, such as an advocate, as appropriate. The purpose of the meeting is to determine needs, coordinate services and training, and develop an Individual Support Plan.

(6) "Case Management" means an organized service to assist individuals to select, obtain and utilize resources and services.

(7) "Case Manager" means an employee of the community mental health program or other agency which contracts with the County or Division, who is selected to plan, procure, coordinate, and monitor individual support plan services and to act as a proponent for persons with developmental disabilities.

(8) "Choice" means the individual's expression of preferences of activities and services through verbal, sign language or other communication method.

(9) "Community Mental Health Program" or "CMHP" means the organization of all services for individuals with mental or emotional disturbances, developmental disabilities, or chemical dependency, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(10) "Crisis Services" means case management services provided in response to any event that substantially threatens the individual's health, safety or the stability of his/her support system.

(11) "Developmental Disability (DD)" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy, or other neurological handicapping condition which requires training or support similar to that required by individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18; and

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the person to function in society; or

(d) Results in significant sub-average general intellectual functioning with concurrent deficits in adaptive behavior which are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision. Mental retardation is synonymous with mental deficiency.

(12) "Developmental Disability Program Manager" means an employee of the community mental health program, or other agency which contracts with the county or Division, who is responsible for DD programs within the county.

(13) "Division" means the Mental Health and Developmental Disability Services Division.

(14) "Entry" means admission to a Division-funded service.

(15) "Exit" means either termination or transfer from one Division-funded program to another. Exit from a program does not include transfer within a service provider's program.

(16) "Generic Services" means community resources that are provided to the citizenry at large.

(17) "Incident Report" means a written report of any injury, accident, act of physical aggression or unusual incident involving an individual.

(18) "Independence" is defined as the extent to which persons with mental retardation or developmental disabilities, with or without staff assistance, exert control and choice over their own lives.

(19) "Individual" means a person with developmental disabilities for whom services are planned and provided.

(20) "Individual Support Plan" or "ISP" means a written plan of support and training services for an individual covering a 12-month period which addresses an individual's support needs and each service provider's program plan.

(21) "Individual Support Plan Team" or "ISP Team" means a team composed of the individual, representatives of all current service providers, case manager, the individual's legal guardian if any, advocate, and others determined appropriate by the individual receiving services. If the individual is unable or does not express a preference, other appropriate team membership shall be determined by the ISP team members.

(22) "Integration" means the use by persons with mental retardation or other developmental disabilities of the same community resources that are used by and available to other persons in the community and participation in the same community activities in which persons without a disability participate, together with regular contact with persons without a disability.

(23) "Legal Representative" means the parent if the individual is under age 18, unless the court appoints another individual or agency to act as guardian. For those individuals over the age of 18, a legal representative means an attorney at law who has been retained by or for the adult, or a person who is authorized by a court to make decisions about services for the individual.

(24) "Local Mental Health Authority" or "LMHA" means the county court or board of county commissioners of one or more counties who chose to operate a CMHP; or, if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation which contracts with MHDDSD to operate a CMHP for that county.

(25) "Monitoring" means the periodic review of the implementation of services identified in the ISP and the quality of services delivered by other organizations.

(26) "Office of Developmental Disability Services" or "DD Office" means the Office of Developmental Disability Services of the Mental Health and Developmental Disability Services Division.

(27) "Priority Population" means individuals possessing one or more of the following characteristics:

(a) The individual has a medical condition that is serious and could be life threatening. Examples include but are not limited to:

(A) Brittle diabetes or diabetes not controlled through medical or physical interventions;

(B) Aspiration or significant risk of choking;

(C) Physical, intellectual, or mental limitations that render the individual totally dependent on others for access to food or fluids;

(D) Mental health or alcohol or drug problems that are not responsive to treatment interventions;

(E) A terminal illness requiring hospice care; and

(F) Condition(s) permitting appointment of a health care representative authorized under OAR 309-041-1500 through 309-041-1610, Health Care Representative.

(b) The individual exhibits behavior that poses a significant danger to the individual. Examples include but are not limited to:

(A) Acts or history of acts which have caused injury to self or others requiring medical attention;

(B) Use of fire or items to threaten injury to persons or damage to property;

(C) Acts that cause significant damage to homes, vehicles, or other property;

(D) Actively searching for opportunities to act out thoughts that involve harm to others.

(c) The ISP team determines that implementation of the Individual's Support Plan developed to address conditions such as those described in (a) or (b) above shall be monitored monthly by the case manager to assure protection of the individual's health and safety. If monthly monitoring by the case manager is not necessary, an individual is not considered part of the priority population.

(28) "Productivity" means engagement in income-producing work by a person with mental retardation or other developmental disabilities which is measured through improvements in income level,

employment status or job advancement or engagement by a person with mental retardation or other developmental disabilities in work contributing to a household or community.

(29) "Service Provider" means a public or private community agency or organization that provides a recognized mental health or developmental disability services services and is approved by the Division or other appropriate agency to provide the service.

(30) "Support" means those services that assist an individual in maintaining or increasing his or her functional independence, achieving community presence and participation, enhancing productivity, and enjoying a satisfying lifestyle. Support services can include training, i.e. the systematic, planned maintenance, development and enhancement of self-care, social or independent living skills; or the planned sequence of systematic interactions, activities, structured learning situations, or educational experiences designed to meet each individual's specified needs in the areas of integration and independence.

(31) "Transfer" means movement of an individual from one site to another site administered by the same service provider.

(32) "Transition Plan" means a written plan for the period of time between an individual's entry into a particular service and the time when the individual's ISP is developed and approved by the ISP team. The plan shall include a summary of the services necessary to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and/or consultations necessary for the ISP development.

(33) "Unusual Incident" means those incidents involving serious illness or accidents, death of an individual, injury or illness of an individual requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, or any incident requiring an abuse investigation.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1320
Community Mental Health Program Responsibilities for Individual Support Plan, Entry/Exit/Transfer Plans

(1) Individuals in Division-funded residential and/or employment services. The CMHP shall assure that all individuals in Division-funded residential and/or employment services have an annual Individual Support Plan (ISP). An Individual Support Plan shall be developed and reviewed in accordance with OAR 309-041-1330 and 309-041-1360. The case manager shall participate in the development of an Individual Support Plan for individuals who fall within the priority population. The case manager shall, to the extent resources are available and within the priorities established in OAR 309-041-0400 through 309-041-0500, Case Management Services for Individuals with Developmental Disabilities and Their Families, participate in the development of Individual Support Plans for other individuals.

(2) Individuals not in Division-funded residential or employment services. Individuals not in Division-funded residential or employment services are not required to have an ISP. These individuals shall have an Annual Contact and Summary of Support Needs developed and reviewed in accordance with OAR 309-041-0410, Case Management Services for Individuals with Developmental Disabilities and Their Families.

(3) Entry/exit/transfer plans for individuals in Division-funded residential or employment services.

(a) Entry to program services shall be authorized in accordance with OAR 309-041-0445, Case Management Services for Individuals with Developmental Disabilities and Their Families.

(b) Exit from program services shall be in accordance with OAR 309-041-0445, Case Management Services for Individuals with Developmental Disabilities and Their Families.

(c) Transfer between program services shall be in accordance with OAR 309-041-0445, Case Management Services for Individuals with Developmental Disabilities and Their Families.

(4) Crisis services for all individuals. Crisis services shall be assessed, identified, planned, monitored and evaluated by the case manager in accordance with OAR 309-041-0300, Diversion/Crisis Services.

(5) Monitoring of individual support plans.

(a) Services identified in the ISP shall be monitored for individuals receiving Division-funded residential and/or employment services in accordance with OAR 309-041-0445, Case Management Services for Individuals with Developmental Disabilities and Their Families.

(b) The case manager shall monitor the ISP for individuals who fall within the priority population. The case manager shall, to the extent resources are available and within the priorities established in the Case Management Rule, monitor the ISP for other individuals.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1330
Standards for the Development of the Individual Support Plan (ISP)

(1) Priority population determination. The ISP team shall make an initial determination whether or not an individual falls within the priority population using the definition in OAR 309-041-0130 and notify the case manager. The case manager shall confirm that the individual falls within the priority population.

(2) ISP team membership. The ISP shall be developed through a team approach and the membership of the team may vary, depending on the unique needs of the individual and the services being provided. Each member shall have equal participation in discussion and decision making. No one member shall have the authority to make decisions for the team. Representatives from service provider(s), families, the CMHP, or advocacy agencies shall be considered as one member for the purpose of reaching majority agreement.

(a) The ISP team shall at a minimum, include the individual, individual's legal guardian, and service provider representatives. The case manager shall be part of the ISP team for individuals who fall within the priority population. The case manager may participate in the ISP meeting for other individuals to the extent case management resources are available and within the priorities set forth for case management services in OAR 309-041-0410, Case Management Services for Individuals with Developmental Disabilities and Their Families.

(b) The individual may suggest additional participants. Typically, family members, advocates or other professionals involved in providing service to the individual are appropriate ISP team members.

(c) The individual may raise objection to participation by a particular person. When an individual raises objections to participation by a particular individual, the team shall attempt to accommodate the individual's objection while allowing participation by team members.

(3) Initial and annual ISP timelines.

(a) An ISP shall be completed within 60 calendar days following entry into Division-funded residential or employment services and at least annually thereafter. All ISPs shall be sent to the CMHP for placement in the individual's file. If the individual has not been identified as a member of the priority population and a case manager believes otherwise, the case manager may reconvene the ISP team. If the case manager does not believe the ISP meets the requirements specified in these rules, the case manager may reconvene the ISP team.

(b) When a service provider's individual planning process (including the outcome system) requires more than annual team meetings, a copy of the plan shall be sent to the CMHP within 30 days of completion for placement in the individual's file. The case manager shall review the plan and provide any comments to the ISP team.

(4) Changes in the ISP. If significant needs or changes or crisis situations arise between scheduled ISP meetings, such as the necessity to develop a new behavior intervention program, reports indicating changes in the health status or functioning level, new evaluations containing substantial recommendations or changes, the report of an unusual incident or any other significant situation which may require prompt action, the case manager or ISP team leader shall be contacted to facilitate a discussion between the ISP team members regarding the ISP changes proposed and assess the need to reconvene as a team. Any ISP team member may contact the case manager regarding changes in the ISP. The case manager or facilitator shall document the team discussion and any subsequent recommendations and distribute to these team members.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1340
ISP Meeting Process

(1) ISP Meetings. The case manager shall initiate the ISP meeting for individuals who fall within the priority population. For other individuals, when the case manager is not present, the ISP team shall select

a team leader for the meeting. The team leader shall be responsible for assuring that the ISP meeting is scheduled and participants notified.

(2) Case manager or team leader role in the development of the ISP. At the ISP meeting, the case manager or designated team leader shall:

(a) Initiate the discussion of the individual, individual's legal representative's, family's, or other team member's preferences;

(b) Initiate a discussion that the individual and/or legal representative have the right to request that information not be shared across service providers unless the preference is likely to create the situation detrimental to the individual's health and safety as determined by the ISP team.

(c) Initiate discussion of and document the need for evaluations in the areas of medical, dental, vision, hearing; and any other evaluations based on the specialized needs of the individual (such as, but not limited to, neurological evaluations for individuals with seizure disorders, augmentative communication evaluations for individuals with limited speech, physical therapy and equipment evaluations for individuals in wheelchairs, psychiatric or psychological evaluations for individuals who are dually-diagnosed or nutritional evaluations for individuals with metabolic disorders);

(d) Initiate and document discussion of specialized health care needs and health maintenance services (such as, but not limited to, required periodic lab work), including what services are needed and the individual or provider who is responsible for assuring that they are provided;

(e) Determine with the ISP team whether home visits, vacations and other community or family-based activities are considered to be community-based experiences preferred by the individual. If so, then these activities must be considered part of the individual's overall ISP and shall be documented as such through the ISP process;

(f) Initiate the review of and discussion regarding outcome of any previous plan;

(g) Initiate discussion of proposed service provider plans and assist the team to make any needed modifications emphasizing health, safety, and rights;

(h) Determine the extent to which the ISP reflects the individual's choice and preferences in his/her daily activities which are defined in the ISP;

(i) Make efforts to build consensus among the members regarding services and supports included in the ISP, giving the most weight to the preference of the individual receiving services, unless the individual's preference is likely to create a situation detrimental to his/her health and safety as determined by the ISP team;

(j) ISP team decisions shall be made by majority agreement.

(3) ISP document. The ISP document shall include:

(a) Each service provider's program plan, with team modifications;

(b) Documentation of the need for additional evaluations or other services to be obtained and the person or provider responsible for assuring that these evaluations or services are obtained;

(c) Documentation of the specialized health care needs, health maintenance services and the person or provider responsible for assuring that these services are provided;

(d) Documentation of the individual's safety skills including the level of support necessary for the individual to evacuate a building (when warned by a signal device), the individual's ability to adjust water temperature, and the amount of time an individual can be without supervision before the missing notification protocol is implemented;

(e) Documentation of the reason(s) any preferences of the individual, legal representative and/or family members cannot be honored; and

(f) Documentation of the role and responsibilities of each participant in implementing the ISP plan, with specific ISP team member concerns, if any, noted.

(4) Distribution of the ISP document. The case manager or the team leader shall assure the distribution of a copy of the Individual Support Plan to all ISP team members within 30 calendar days of the ISP team meeting.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1350
ISP Team Responsibilities for Entry/Exit/Transfer

(1) Entry staffing. Prior to an individual's date of entry into a Division-funded program, the ISP team shall meet to review referral material in order to determine appropriateness of placement. For purposes for entry staffings, a case manager must attend the staffing and authorize the placement. The team shall determine date of entry and develop a transition plan. The transition plan shall include:

(a) The name of the individual considered for entry;

(b) The date of the meeting;

(c) Documentation of the participants included in the meeting;

(d) Documentation of the circumstances leading to the proposed entry;

(e) Documentation of the alternatives considered instead of entry;

(f) Documentation of the reason(s) any preferences of the individual, the individual's legal representative, family or other team member cannot be honored;

(g) Documentation of majority agreement of the participants in the meeting with the decision;

(h) The written plan for services to the individual;

(i) Documentation of decisions regarding the proposed placement; and

(j) Findings of the ISP team and the signatures of all participants.

(2) Crisis services. For a period not to exceed 30 days, subsection (3)(b) of OAR 309-041-0445 does not apply if an individual is temporarily admitted to a program for crisis services.

(3) Exit from Division-funded programs. All exits from Division-funded programs shall be authorized by the CMHP. Prior to an individual's exit date, the ISP team shall meet to review the appropriateness of the move and to coordinate any services necessary during or following the transition. For purposes for exit staffings, a case manager must attend the staffing and authorize the exit.

(4) Exit staffing. Findings of the exit meeting shall be distributed to all ISP team members. The exit plan shall include:

(a) The name of the individual considered for exit;

(b) The date of the meeting;

(c) Documentation of the participants included in the meeting;

(d) Documentation of the circumstances leading to the proposed exit;

(e) Documentation of the alternatives considered instead of exit;

(f) Documentation of the reason(s) any preferences of the individual, the individual's legal representative, family or other team member cannot be honored;

(g) Documentation of majority agreement of the participants in the meeting with the decision; and

(h) The written plan for services to the individual.

(5) Transfer meeting. All transfers must be authorized by the CMHP. Transfer of an individual shall be preceded by a meeting of the ISP team before any decision to transfer is made. This meeting may occur by phone with all ISP team participants to expedite the transfer if so warranted. Findings of such a meeting shall be recorded in the individual's file and include, at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the meeting;

(c) Documentation of the participants included in the meeting;

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternatives considered instead of transfer;

(f) Documentation of the reason(s) any preferences of the individual, individual's legal representative and/or family members cannot be honored;

(g) Documentation of majority agreement of the participants with the decision; and

(h) The written plan for services to the individual after transfer.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1360
Standards for Monitoring Individual Support Plans for Individuals

(1) Case manager responsibility for monitoring services for individuals. The case manager shall determine whether services are being provided in accordance with the ISP; that personal, civil, and legal

rights of the individual are protected in accordance with this rule; that the satisfaction and desires of the individual, the individual's legal representative or family are addressed; that the services provided continue to meet the needs of the individual; and that the services result in the individual's achievement of goals and objectives identified in the ISP. The case manager shall monitor the ISP for individuals who fall within the priority population. The case manager shall, to the extent resources are available, monitor the ISP of other individuals.

(2) Frequency of monitoring. The frequency of the monitoring will be determined by the needs of the individual. However, the case manager shall meet at least monthly, in addition to the annual ISP meeting, with an individual who falls within the priority population. Arrangements shall be made to meet with the individual in a mutually acceptable location. Communication for the purpose of monitoring may also be done with provider(s) and family members. Should an individual refuse, after being duly informed as to the purpose and nature of the visit, to have the case manager visit, then such a refusal shall be documented in the individual's case record.

(3) Purpose of monitoring. The purpose of the visit is to assure that supports are being provided as defined in the ISP. Monitoring shall include:

(a) Review and documentation of the individual's outcome data, if applicable.

(b) Review of any incident and unusual incident reports.

(c) Review of the process by which an individual accesses and utilizes funds according to standards specified in OAR 309-049-0175.

(d) Review of the ISP document to determine if the goals and objectives or actions to be taken by the case manager or others have been implemented:

(A) Address the individual's participation in activities that will increase integration, independence, and/or productivity;

(B) Address the anticipated outcomes which reflect the preferences and needs of the individual to the extent possible, while at the same time reflect similar interests and activities of persons without disabilities of a similar age; and

(C) Define the behavior, conditions and criterion for achieving the objectives and are consistent with the residential or employment outcome system as set forth in the Interagency Agreement between the Division and the CMHP.

(4) Monitoring follow-up. If the case manager determines that services are not being delivered as agreed, or that an individual's service needs have changed since the last review, the CMHP shall determine the need for technical assistance and/or referral to the DD program manager for consultation or corrective action.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1370
Grievance Procedures

(1) Grievances.

(a) Mediation of grievances. Individuals, their legal representatives, family members or advocates may file a grievance concerning a determination regarding the appropriateness of services proposed or provided as set forth in these rules.

(b) Grievances shall be submitted in writing to the CMHP. The CMHP upon request shall assist individuals requiring assistance in preparing a written grievance.

(c) Informal procedures. Grievances concerning the appropriateness of services should, if possible, be resolved through the use of informal procedures. However, the grievant may elect not to utilize informal procedures, and to proceed directly to the county formal mediation committee.

(A) Informal procedures may include one or more of the following:

(i) Meeting with the individual, legal representative, family member(s) and/or advocates;

(ii) Meeting with the CMPH administrative staff;

(iii) Meeting with the ISP team;

(iv) Meeting with program administrative staff; and

(v) Meeting with local agency(ies); and

(vi) Voluntary mediation with a neutral mediator mutually agreed upon by the parties.

(B) Informal procedures shall result in a decision on the grievance no later than 30 days from the date the grievance is filed.

(C) The 30 day period for informal resolution of grievances may be extended by mutual agreement of the grievant and the CMHP to extend the informal process. Such agreement shall be in writing and must extend the process for a specified duration. A copy of the agreement to extend the time for informal resolution shall be sent to the CMHP and the Division within five working days of its signing by the parties involved.

(D) The grievant shall receive written notice of the grievance decision or outcome. The CMHP shall send a copy of this notice to the Division within five working days of issuance of notice to the grievant.

(d) CMHP formal mediation. When informal procedures cannot resolve the dispute, the interested party(ies) may submit to the CMHP a written request for a formal mediation of the disagreement using the CMHP's mediation procedures. The CMHP Director or designee shall make a decision within 30 working days of receipt of the request and notify the appellant of the decision in writing.

(e) Division review process. If the CMHP formal mediation decision is not acceptable to all the parties, decisions can be reviewed using the following formal procedure:

(A) The party requesting review shall submit in writing a request for a formal review to the Mental Health and Developmental Disability Services Division within five working days of receipt of the CMHP's decision:

(i) A grievance review committee shall be appointed by the Administrator of the Division or designee, in the Office of Developmental Disability Services of the Division, every two years, and shall be composed of Division representative, a local service provider program representative, a case management representative, and a representative of the Division's Office of Client Rights;

(ii) In case of a conflict of interest, as determined by the Administrator or designee, alternative representatives will temporarily be appointed to the committee by the Administrator or designee.

(B) Upon receipt of the request for formal review, the Division shall:

(i) Schedule a grievance committee review meeting within 30 days of written request by the requesting party for a formal review of the decision; and

(ii) Notify in writing, each party involved in the disagreement of the date, time, and location of the committee review meeting, allowing at least 15 days from the meeting notification to the scheduled meeting time; and

(iii) Record the review committee meeting.

(C) Individual rights. The grievance review committee shall afford individuals the following rights:

(i) The opportunity to review documents and other evidence relied upon in reaching the decision being appealed; and

(ii) The opportunity to be heard in person and to be represented; and

(iii) The opportunity to present witnesses or documents to support their position and to question witnesses presented by other parties.

(D) Within 15 days after the conclusion of the meeting, the grievance review committee shall provide written recommendations to the Administrator or designee. The Administrator or designee shall make a decision and send written notification of the recommendations and implementation process to all grievance review committee meeting participants within 15 days of receipt of the recommendations.

(E) The decision of the Administrator or designee shall be final.

(2) Appeals.

(a) Appeals of entry, exit or transfer decisions within residential services may only be initiated according to the "24-Hour Residential Services" (OAR 309-049-0030), and the "Supported Living Services" (OAR 309-041-0550) and "Semi-Independent Living Services" (OAR 309-041-0015) rules;

(b) Appeals of entry, exit or transfer decisions within employment services may only be initiated according to the "Employment and Alternatives to Employment Services" (OAR 309-047-0000) rule.

Stat. Auth.: ORS 430.041
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: MHD 9-1997, f. & cert. ef. 10-9-97

309-041-1500 [Renumbered to **411-365-0100**]

309-041-1510 [Renumbered to **411-365-0120**]

309-041-1520 [Renumbered to **411-365-0140**]

309-041-1530 [Renumbered to **411-365-0160**]

309-041-1540 [Renumbered to **411-365-0180**]

309-041-1550 [Renumbered to **411-365-0200**]

309-041-1560 [Renumbered to **411-365-0220**]

309-041-1570 [Renumbered to **411-365-0240**]

309-041-1580 [Renumbered to **411-365-0260**]

309-041-1590 [Renumbered to **411-365-0280**]

309-041-1600 [Renumbered to **411-365-0300**]

309-041-1610 [Renumbered to **411-365-0320**]

DIVISION 42

STATE TRAINING CENTERS FOR THE MENTALLY RETARDED

309-042-0000
Admission and Release of Residents

(1) Purpose. These rules prescribe criteria for voluntary admission of a person to a state training center for persons with mental retardation and criteria for the examining authority's recommendation to a court on commitment of a person alleged to have mental retardation to the Mental Health and Developmental Disability Services Division. These rules also prescribe a procedure for the release of certain residents from state training centers for persons with mental retardation.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS Chapters 179 and 427.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 31-1975, f. 9-5-75, ef. 9-26-75; MHD 1-1979(Temp), f. & ef. 1-26-79; MHD 3-1979, f. & ef. 5-24-79; MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0001
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Community Mental Health Program (CMHP)" means the organization of all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by, or contractually affiliated with, a local mental health authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Mental Health and Developmental Disability Services Division.

(3) "Diagnosis and Evaluation Service" means the designated unit of the Mental Health and Developmental Disability Services Division created by ORS 427.104 to approve applications for admission to state training centers; process and coordinate all placements of residents from state training centers; consult on diagnostic evaluations statewide; provide information to the State Training Center Review Board, as appropriate; and provide consultation to appropriate agencies and individuals regarding persons evaluated, and diagnosis and evaluation services.

(4) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(5) "Examining Authority" means any program designated by the Diagnosis and Evaluation Service to act as an examining authority for the purpose of these rules.

(6) "Facility" means a state training center, community hospital, group home, activity center, intermediate care facility, community mental health clinic, or such other facilities or programs as the Division approves to provide necessary services to persons with mental retardation or developmental disabilities.

(7) "Mental Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "**Manual on Terminology and Classification in Mental Retardation**" of the American Association on Mental Deficiency, 1977 Revision. Mental retardation is synonymous with mental deficiency:

(a) "Adaptive Behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for age and cultural group;

(b) "Developmental Period" means the period of time between birth and the 18th birthday;

(c) "Intellectual Functioning" means functioning as assessed by one or more of the individually administered general intelligence tests developed for the purpose;

(d) "Significantly Subaverage" means a score on a test of intellectual functioning that is two or more standard deviations below the mean for the test.

(8) "Specialized Back-up" means provision of services, such as respite care or time-limited intensive treatment and training, not currently available or appropriate for an individual in any other facility or program operated or supported by the Division for the care, treatment, and training of the person with mental retardation.

(9) "State Training Center" means Fairview Training Center; and Eastern Oregon Training Center operated for specialized back-up care, treatment, and training of persons with mental retardation.

(10) "State Training Center Review Board" means the Board created by ORS 427.205.

(11) "Warrant of Detention" means the legal process by which a person alleged to have mental retardation who is thought to pose an imminent and serious danger to the person or others may be ordered by a court to be detained by custody pending an investigation and possible commitment hearing.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 31-1975, f. 9-5-75, ef. 9-26-75; MHD 1-1979(Temp), f. & ef. 1-26-79; MHD 3-1979, f. & ef. 5-24-79; MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0002
General Policy

The role of state training centers is to serve as specialized back-up facilities to a primary system of community-based services for persons with mental retardation and other developmental disabilities.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0003
Admission Criteria

(1) Before a person will be accepted for voluntary admission to a state training center, or before an examining authority may recommend to a court commitment to the Division of a person alleged to have mental retardation, or before the Division directs a court-committed person to be admitted to a state training center or other facility, the Diagnosis and Evaluation Service shall:

(a) Receive written documentation prior to admission from the community mental health program of attempts to secure appropriate services for the person in the county in which the person resides, and, all adjacent counties, and, the reasons such attempts were unsuccessful. In an effort to avoid the need for admission, the Division shall assist community mental health programs in attempts to locate appropriate community services in other parts of the state;

(b) Determine that an examining authority has found the person to have mental retardation based upon the "**Manual on Terminology and Classification in Mental Retardation**" of the American Association on Mental Deficiency, 1977 Revision. The examination shall include a comprehensive evaluation covering physical, social, and cognitive factors and considering past and present behavior of the person. Persons of borderline intelligence may be considered to have mental retardation if there is also serious impairment to adaptive behavior,

unless the examiner can definitely attribute the adaptive deficits to such factors as mental or emotional disturbance, sensory impairments, or other such variables. However, the examiner shall include a recommendation as to whether admission to a state training center is in the best interest of the person with borderline intelligence;

(c) Determine that admission to a state training center for time limited specialized services is the optimal available plan, is in the best interest of the person and the community, appropriate residential space is available, and programs are available at the state training center that can treat or habilitate the person's problems that brought about the need for admission. The Mental Health Division may create a "wait list" for admission to a state training center if the state training center does not have space available in an appropriate unit;

(d) Develop an agreement with the respective community mental health program and the state training center that clearly documents in measurable terms the training needs of the person and the programming that needs to occur during the stay. The agreement will report the expected duration of the admission and specify how the Diagnosis and Evaluation Service, community mental health program and the state training center will be involved in planning for the expeditious return of the person to a community program.

(2) Persons committed to the Mental Health and Developmental Disability Services Division pursuant to ORS 426.060, 161.370 or 161.341 and who also meet the requirements of this section may be admitted to a state training center by transfer from other Division institutions pursuant to ORS 161.390 and OAR 309-031-0010.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 31-1975, f. 9-5-75, ef. 9-26-75; MHD 1-1979(Temp), f. & ef. 1-26-79; MHD 3-1979, f. & ef. 5-24-79; MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 19-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0004
Custody Pending Investigation

A warrant of detention may be issued and the person admitted to a state training center for custody and diagnostic evaluation if the court finds there is probable cause to believe that failure to take the person into custody pending an investigation or hearing would pose an imminent and serious danger to the person or others. However, the community mental health program must comply with admission criteria in OAR 309-042-0003, if the client is to be considered for admission to the state training center after the warrant of detention elapses.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0005
Diagnostic Evaluation

(1) The Diagnosis and Evaluation Service shall assure the provision of diagnostic evaluations required by ORS 427.105, and shall assure that diagnostic evaluations are in compliance with standards for diagnostic evaluations as defined by OAR 309-042-0050.

(2) The diagnostic evaluation report shall:

(a) Include a recommendation as to the type of treatment or training facility best able to habilitate the person;

(b) Advise the court whether, in the opinion of the examining facility, the person with mental retardation and, if the person is a minor or incapacitated, the person's parents or legal guardian would cooperate with voluntary treatment or training; and

(c) Advise the court whether the person would benefit from voluntary treatment or training or from appointment of a legal guardian or conservator.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0006
Admission Procedure

(1) The Diagnosis and Evaluation Service shall:

(a) Normally schedule pre-admission evaluations of persons in the following order:

(A) Persons being held on a warrant pending court hearing for involuntary commitment and other cases determined to be most urgent by the Administrator of the Division, or designee;

(B) Persons being examined for commitment under ORS 427.290;

(C) Persons being examined for admission under ORS 427.185;

(D) Patients and residents being referred from Division institutions.

(b) Ensure that the prospective resident and/or the resident's parent, guardian, or other responsible person has been counseled before admission on the relative advantages and disadvantages of services in a state training center;

(c) Ensure that, before admission, the prospective resident and/or the resident's parent, guardian, or other responsible person, as appropriate, has an opportunity, and is apprised of the opportunity, to visit the living unit in which the prospective resident is likely to be placed;

(d) Ensure that, before admission, the prospective resident and/or the resident's parent, guardian, or other responsible person, understands that the admission will be time limited; and an immediate and ongoing search for a community alternative will occur; and the resident will be relocated in a community program appropriate to his or her needs as soon as such a program is identified or developed;

(e) Initially define the prospective resident's immediate and most critical care, treatment, and training needs, including the reason or reasons for admission as the top priority for treatment and training on the admission plan of care;

(f) Investigate and weigh all available and applicable care, treatment, and training services and record its deliberations and findings;

(g) Clearly specify the problems requiring the admission.

(2) The Mental Health and Developmental Disability Services Division may direct any court committed person with mental retardation to any state operated or supported facility or program best able to provide necessary care, treatment, or training. The Division shall consult with any community mental health program or service provider affected by a decision made under this section.

(3) The superintendent of a state training center shall:

(a) Admit as a resident and take custody of only such persons authorized for admission by the Coordinator of the Diagnosis and Evaluation Service;

(b) Ensure that the number of admissions does not exceed the licensed capacity of the state training center or its provisions for adequate programming;

(c) Consider all admissions temporary and limit the duration of admissions when such limitation is appropriate according to the superintendent's best professional judgment.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1979(Temp), f. & ef. 1-26-79; MHD 3-1979, f. & ef. 5-24-79; MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0007
Priority for Admissions

The Diagnosis and Evaluation Service shall maintain a waiting list for admission to state training centers:

(1) Persons are entitled to admission to state training centers in the order in which completed applications are received and filed.

(2) Persons may be admitted on a priority basis by the Coordinator of the Diagnosis and Evaluation Service if their behavior or condition is a threat to their welfare or safety or to the safety of others.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0008
Appeals

Any decision made by the Diagnosis and Evaluation Service regarding admission or the current status of a resident's eligibility for continued care in a state training center can be appealed by the person, or other persons on his or her behalf, to the Administrator of the Division, or designee:

(1) The appeal must be filed within 30 days of receipt of notice of the decision and shall set forth reasons for the appeal.

(2) The Administrator, or designee, shall convene the State Training Center Review Board within 30 days of receipt of the appeal.

(3) The Board shall advise the Administrator, or designee, regarding disposition of the appeal.

(4) The Administrator, or designee, shall make the decision within 30 days of the meeting of the Board.

(5) The decision of the Administrator, or designee, shall be final.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0009
Procedures for Release of Certain Residents from State Training Centers

Before the discharge of any resident for reason of ineligibility who scores in the 59–79 range on a test of intellectual functioning, the state training center having custody of the resident shall require a re-examination of the resident to be coordinated by the Diagnosis and Evaluation Service:

(1) Upon receipt of a request from the state training center, the Diagnosis and Evaluation Service shall assure that an examination is conducted to determine the current status of the resident's eligibility for care in a state training center.

(2) If the results of this examination differ significantly, in the opinion of the examining authority, from the most recent examination conducted by the state training center, the examining authority shall arrange for a special examination of the resident by a psychologist who is not an employee of the State of Oregon.

(3) The Diagnosis and Evaluation Service shall report its findings and the results of the special examination referred to in section (2) of this rule, if any, to the state training center in not more than three calendar days after completion of the examination.

(4) After receiving and considering the examination results, the state training center may proceed to discharge the resident. All reports and findings from examination of the resident shall be added to, and become a part of, the central record of that resident.

Stat. Auth.: ORS 179, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1979(Temp), f. & ef. 1-26-79; MHD 3-1979, f. & ef. 5-24-79; MHD 10-1979(Temp), f. & ef. 10-31-79; MHD 10-1980, f. & ef. 4-25-80; MHD 11-1983, f. & ef. 6-10-83; MHD 6-1987, f. & ef. 8-24-87

309-042-0015
Crisis Intervention and Respite Care

(1) Purpose. This rule prescribes procedures for the delivery of crisis intervention and respite care in state training centers for the mentally retarded.

(2) Statutory Authority and Procedures. This rule is authorized by ORS 430.041(1) and carries out the provisions of Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142).

(3) Definitions. As used in this rule:

(a) "Community Mental Health Program" means all service elements for mentally retarded and developmentally disabled persons that participate within a comprehensive community mental health program through a contract or affiliation agreement;

(b) "Crisis Intervention" means a short-term admission of a person to a state training center for crisis relief in those extreme situations specified in the eligibility criteria section (4) of this rule.

(c) "Diagnosis and Evaluation Service" means the unit of the Mental Health and Developmental Disability Services Division that authorizes admission to state training centers for the purposes of crisis intervention and respite care.

(d) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(e) "Respite Care" means a short-term admission of a person to a state training center to provide temporary relief for the family or other person(s) responsible for daily care of the person seeking admission.

(f) "Short-Term Admission" means the presence of a person at a state training center for 24 hours a day for a specific period of not more than 90 continuous days.

(g) "State Training Center" means Fairview Training Center; that part of Eastern Oregon Hospital and Training Center operated for the care, treatment, and training of mentally retarded persons; and any other facility operated by the Mental Health and Developmental Disability Services Division for the care, treatment, and training of the mentally retarded.

(h) "State Training Center Review Board" means the Board created by Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142), codified as ORS 427.205.

(4) Eligibility. A person shall be eligible for admission to a state training center for:

(a) Crisis intervention if:

(A) The life, health, or safety of the person is in immediate danger; or

(B) The behavior or condition of the person is an immediate threat to the safety of the others; and

(C) The person meets eligibility criteria established in OAR 309-042-0000; and

(D) The community mental health program and the Diagnosis and Evaluation Service determine that no adequate alternative to admission to a state training center exists in the community; and

(E) There is reasonable assurance of the return of the person to the community at the termination of admission for crisis intervention.

(b) Respite care if:

(A) The person meets eligibility criteria established in OAR 309-042-0000; and

(B) There is reasonable assurance of the return of the person to the community at the termination of admission for respite care.

(c) Precommitment examination if:

(A) The Diagnosis and Evaluation Service deems admission necessary to make the diagnostic evaluation required for voluntary admission to a state training center or involuntary commitment to the Division; and

(B) The person shall not be kept in residence in a state training center for a diagnostic evaluation for a period longer than ten business days; and

(C) The court issues a warrant of detention when it believes an imminent or serious threat to the person or others exists.

(5) Standards and Procedures Governing Crisis Intervention or Respite Care:

(a) Requests shall be granted only when it is reasonably clear that the need for crisis intervention or respite care is likely to be met by institutionalization for a period of time not to exceed 90 days. In other situations, application shall be made for regular admission in accordance with OAR 309-042-0000. The request shall be made by the person to be seeking admission, or those immediately responsible for the person's care, to the community mental health program of the county of residence of the person;

(b) Immediately upon receipt of a request for crisis intervention, the community mental health program shall:

(A) Obtain information regarding the history and condition of the person;

(B) Determine the nature and urgency of the circumstances that led to the request for short-term admission; and

(C) Determine the availability of appropriate local alternatives to meet the situation — that is, inpatient treatment in community residential facilities.

(c) If, with the concurrence of the Diagnosis and Evaluation Service, it is determined that no adequate local alternative placement is available and the person appears eligible for short-term admission, the community mental health program shall immediately refer the request and all appropriate information about the person to the Chief of the Diagnosis and Evaluation Service for determination of the appropriateness of short-term admission;

(d) If the person is eligible and needs crisis intervention and appropriate space for the person's care and treatment is available in a state training center, the person shall be immediately admitted as a short-term admission. The Diagnosis and Evaluation Service may enlist the assistance of the state training center or community mental health program in evaluating the person's eligibility and the necessity of admission;

(e) If during the course of admission for crisis intervention or respite care, the state training center or community mental health program determines that the needs of the person or the person's plan for subsequent release and placement have changed so that short-term admission is no longer adequate, the Diagnosis and Evaluation Service shall be so notified. The Diagnosis and Evaluation Service may initiate appropriate action in accordance with OAR 309-042-0000 if the change(s) warrant consideration of an admission to a state training cen-

ter for an indefinite period, or for a specified time period of more than 90 days.

(6) Duration of Crisis Intervention or Respite Care:

(a) Projected duration of stay shall be determined and approved by the Diagnosis and Evaluation Service before admission;

(b) Crisis intervention or respite care shall not routinely exceed 60 consecutive days and, in no instance, exceed 90 consecutive days in duration;

(c) A person shall be eligible for respite care for a combined total number of days not to exceed 180 days within a 12-month period.

(7) Fee Schedule for Crisis Intervention or Respite Care. Fees for crisis intervention or respite care shall be established by the Division and will be charged to the person admitted to the state training center or to his estate or third-party payor.

(8) Appeal From Denial of Requested Crisis Intervention or Respite Care: Any decision made by the Diagnosis and Evaluation Service regarding crisis intervention or respite care can be appealed by the person seeking admission or other person on his behalf to the Administrator of the Division, or his designee:

(a) The appeal must be filed within 30 days of receipt of notice of the decision and shall set forth reasons for the appeal;

(b) The Administrator, or his designee, shall convene the State Training Center Review Board within 30 days of receipt of the appeal;

(c) The Board shall advise the Administrator, or his designee, regarding disposition of the appeal;

(d) The Administrator, or his designee, shall make his decision on the appeal within 30 days of the meeting of the Board;

(e) The decision of the Administrator, or his designee, shall be final.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 44, f. & ef. 7-20-77; MHD 11-1979(Temp), f. & ef. 10-31-79; MHD 11-1980, f. & ef. 4-25-80

309-042-0030
Annual Review and Certification of Residents for Continued Residential Care and Training

(1) Purpose. This rule prescribes procedures for an annual review of each resident's plan of care and presentation of certification of the resident's eligibility and need for continued residential care and training in a state training center to the State Training Center Review Board.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 430.041(1) and carries out the provisions of Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142).

(3) Definitions. As used in this rule:

(a) "Care" means supportive services, including, but not limited to, provision of room and board; supervision; protection; and assistance in bathing, dressing, grooming, eating, management of money, transportation, or recreation;

(b) "Central Record" means the principal individual case document for each resident that contains for safekeeping the pertinent clinical and programmatic data;

(c) "Central Records" means the department responsible for the documentation, storage, and safekeeping of pertinent clinical and programmatic data pertaining to each resident in a state training center;

(d) "Certification" means the formal decision of the state training center Unit Interdisciplinary Team to continue the resident's care and training in the state training center for a period up to 12 months;

(e) "Commitment" means the assignment of a person to custody, confinement, or treatment by court order to the Mental Health and Developmental Disability Services Division;

(f) "Diagnosis" means a concise description of the distinguishing characteristics of a condition as described in the **"Manual on Terminology and Classification in Mental Retardation" of the American Association on Mental Deficiency, 1977 Revision**;

(g) "Direct care staff" means state training center employees having responsibility for the day-to-day care of the residents;

(h) "Discharge" means the permanent separation of the resident from the state training center. If the resident has been civilly committed, discharge also means termination from commitment. The term "release" is synonymous with discharge;

(i) "Disposition Board" means an administrative, clinical, and community consumer body appointed by the Superintendent to assess the release and/or discharge plans of residents before the Superintendent approves their return to the community and permanent separation from the state training center;

(j) "Eligibility" means the state of being qualified by reason of being mentally retarded;

(k) "Facility" means a state training center;

(l) "Level of Functioning" means a person's intellectual and adaptive behavior capabilities;

(m) "Long-Term Goal" means a goal achievable within two or more years;

(n) "Mental Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **"Manual on Terminology and Classification in Mental Retardation" of the American Association on Mental Deficiency, 1977 Revision**. Mental retardation is synonymous with mental deficiency:

(A) "Adaptive Behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for age and cultural group.

(B) "Developmental Period" means the period of time between birth and the 18th birthday.

(C) "Intellectual Functioning" means functioning as assessed by one or more of the individually administered general intelligence tests developed for that purpose.

(D) "Significantly Subaverage" means a score on the test of intellectual functioning that is two or more standard deviations below the mean for the test.

(o) "Plan of Care Review" means the annual assessment of the progress of each resident toward long- and short-term program goals established by the Unit Interdisciplinary Team and assessment of the appropriateness of those goals.

(p) "Post-Institutional Plan of Care" means that part of the Plan of Care review that describes the type of living and day plans needed by the resident to accomplish release from the facility and permanent residence in a community-based facility.

(q) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401**.

(r) "Resident" means a person admitted to a state training center either voluntarily or after commitment to the Mental Health Division.

(s) "Short-Term Goal" means a goal achievable in less than two years. The estimated achievement date is specified in the Plan of Care.

(t) "State Training Center" means Fairview Training Center; that part of Eastern Oregon Hospital and Training Center operated for the care, treatment, and training of mentally retarded person; and any other facility operated by the Mental Health Division for the care, treatment, and training of the mentally retarded.

(u) "State Training Center Review Board" means the Board created by Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142), codified as ORS 427.205.

(v) "Superintendent" means the executive head of Fairview Training Center and the executive head of Eastern Oregon Hospital and Training Center.

(w) "Training" means the systematic, planned maintenance, development, or enhancement of self-care, social or independent living skills; or the planned sequence of systematic interactions, activities, structured learning situations, or education designed to meet each resident's specified needs in the areas of physical, emotional, intellectual, and social growth.

(x) "Unit" means a group of specified residential living areas, wards, cottages, or buildings within a state facility.

(y) "Unit Director" means the administrative head of a designated living unit within a state training center.

(z) "Unit Interdisciplinary Team" means a group consisting of professional and direct care staff, usually including, but not limited to, representatives from social services, psychology, education, medicine, and direct care services. The team shall be chaired by a qualified mental retardation professional. Its function is to prescribe the overall individual program for each assigned resident.

(4) General Description:

(a) The annual Plan of Care is designed to assess the progress of each resident and prescribe long- and short-term program goals

according to the resident's needs. The resident's Unit Interdisciplinary Team shall conduct the reviews;

(b) At the time of the annual Plan of Care review meeting, the chairperson of the Unit Interdisciplinary Team shall make provision for advising and adequately explaining to the resident the facility's statement of resident rights and the policies and rules governing the resident's living area;

(c) The annual review shall include determination of the resident's mental retardation based on standardized measures of intelligence and adaptive behavior and the need for continued residential care and training. Residents determined eligible and in need of continued residential care and training shall be certified for one year and presented with clear and convincing justification to the State Training Center Review Board for review and action;

(d) The State Training Center Review Board shall approve or disapprove the facility's certification of the resident. If the certification is approved, the resident will be certified to remain at the state training center for a period up to 12 months. If the certification is disapproved, the Superintendent shall discharge the resident; or, if discharge is determined not in the resident's best interest, the Superintendent shall seek a court commitment;

(e) The resident and the resident's parent, guardian, or person entitled to custody shall be notified in writing of the facility's intent to certify the resident for continued residential care and training; and the resident shall be advised of the right to object. In addition, the resident shall be orally advised of the facility's intent to certify;

(f) **Exhibit A** is a flow chart of the review and certification process described in this rule.

(5) Contents of Plan of Care. The Plan of Care for each resident shall include, but not be limited to, the following:

(a) Current diagnosis;

(b) Level of functioning;

(c) Current habilitation and health programs in which the resident is participating;

(d) Statement as to continued eligibility and continued need for residential care;

(e) Statements of long- and short-term goals for the resident; and

(f) Verification that the person has been advised of the facility's statement of resident's rights and the policies governing the resident's immediate living area.

(6) Notification of Intent to Certify Need for Continued Residential Care and Training:

(a) The state training center shall notify the following persons of their intent to certify the need for the resident's continued residential care and training:

(A) The resident, orally;

(B) The resident and the resident's parent, guardian, or person entitled to custody, in writing, by certified mail.

(b) The written notification shall include the following:

(A) Date, time, place, and location of the State Training Center Review Board hearing;

(B) Explanation of the possible consequences of the proceedings;

(C) Explanation of the resident's right to appear before the board on his or her own behalf or to be represented at the proceeding by the resident's parent, guardian, the person entitled to custody, or another person, including counsel, of the resident's choosing; and

(D) Explanation of the resident's right to object to certification and its consequences.

(c) In the event the resident, because of severe disability, is unable to receive and acknowledge the notification required by subsection (b) of this section, that fact shall be documented in the resident's central record and conveyed to the State Training Center Review Board on the Checklist/Cover Sheet accompanying the copy of the Plan of Care.

(7) Certification of Need for Continued Residential Care and Training:

(a) The resident shall be scheduled to receive an annual Plan of Care review by the appropriate assigned Unit Interdisciplinary Team:

(A) The Plan of Care review shall include, but not be limited to, participation and/or data contributions from the chairperson of the Unit Interdisciplinary Team; a unit representative from the direct care staff; and assigned social worker, physician, and psychologist;

(B) The Plan of Care review shall consider all, but not be limited to, items listed in subsections (5)(a) through (f) of this rule:

(i) The psychologist assigned to the unit shall assess the resident's overall intellectual and adaptive behavior functioning levels to determine the resident's eligibility based on OAR 309-042-0000. If the resident is found to be mentally retarded as described in OAR 309-042-0000, the resident is eligible. If, in the psychologist's professional opinion, current testing is not indicated, the psychologist shall state the reasons why testing is not indicated at that time and further state support of the last psychological assessment(s). These assessments or statements shall be the evidence supporting or not supporting eligibility;

(ii) The Unit Interdisciplinary Team shall develop a Post-institutional Plan of Care for each resident that shall indicate the type of living facility and day program that will be needed by the resident if community placement is to be accomplished. The chairperson of the Unit Interdisciplinary Team shall secure from the Diagnosis and Evaluation Service (Exit Team) of the Mental Health and Developmental Disability Services Division confirmation in writing of the availability or non-availability of community services to accomplish the Post-institutional Plan. This written statement shall be the evidence supporting the need for continued residential care and training on the basis that a community alternative plan is not currently available.

(C) The Unit Interdisciplinary Team shall make the decision to certify or not to certify the resident based on the data considered within the Plan of Care with particular attention to eligibility (determination of mental retardation) and availability of an appropriate Post-institutional Plan;

(D) The resident shall be notified orally, at the Plan of Care review, of the state training center's intent to certify or not to certify the resident's continued residential care and training;

(E) When the state training center intends to certify for continued residential care and training, the resident shall be advised of the right to object.

(i) The resident shall be notified of the consequences of any objection, which may be:

(I) The resident may be discharged;

(II) The Superintendent of the state training center may initiate commitment proceedings if discharge is considered not in the best interest of the resident.

(ii) The resident, with the assistance of an assigned social worker, shall submit any objection in writing to the Unit Director within ten days after receipt of the notice of certification;

(iii) If the resident agrees with the certification for continued residential care and training following oral notification, subsection (b) of this section can be undertaken;

(iv) If the resident objects to continued certification for residential care and training following oral notification, or at a later date following written notification, the following procedures will be followed:

(I) The objection will be noted in the appropriate place on the Checklist/Cover Sheet and the resident's central record;

(II) The recommendation of the Unit Interdisciplinary Team, together with the objection, if any, will be immediately forwarded by the Unit Director with the Checklist/Cover Sheet to the chairperson of the Disposition Board;

(III) The chairperson of the Disposition Board will schedule a hearing of the resident's objection to continued residential care and training. The resident and a representative of the Unit Interdisciplinary Team will be present at the Disposition Board hearing. The Disposition Board, after considering the facts of the case, shall make a recommendation to the Superintendent of the state training center regarding continued certification of the resident and initiation of commitment proceedings or discharge of the resident;

(IV) The Superintendent will act upon the recommendation of the Disposition Board by either discharging the resident, or initiating commitment proceedings pursuant to Chapter 683, Oregon Laws 1979, codified as ORS 427.235 to 427.270, 427.280 and 427.285.

(F) When the Unit Interdisciplinary Team decides certification for continued residential care and training is not appropriate, the following procedure will be followed:

(i) The recommendation will be noted in the appropriate place on the Checklist/Cover Sheet and forwarded to Central Records for notation;

(ii) Central Records will note and forward the recommendation to the chairperson of the Disposition Board;

(iii) The chairperson of the Disposition Board shall schedule a hearing relative to the proposed discharge of the resident:

(I) The resident and a representative of the Unit Interdisciplinary Team shall be present at the Disposition Board hearing;

(II) The Disposition Board, after considering the facts of the case, shall make a recommendation to the Superintendent of the state training center regarding the resident's discharge or continued residential care and training.

(iv) The Superintendent shall act upon the recommendation of the Disposition Board:

(I) If discharge is recommended, the Superintendent shall direct Central Records and the resident's Unit Director to discharge the resident;

(II) If continued residential care and training is recommended, the Superintendent shall direct the Unit Director to proceed under paragraph (a)(C) of this section to certify the resident's continued residential care and training based on the findings of the Disposition Board.

(v) When recommendation of the Disposition Board is for continued residential care and training, contrary to the Unit Interdisciplinary Team's recommendation, and the Superintendent agrees with the Disposition Board, the Unit Director will be notified to reconvene the appropriate Unit Interdisciplinary Team and proceed under paragraph (a)(C) of this section to certify the resident's continued residential care and training based on the facility's Disposition Board findings;

(b) The Unit Director shall retain the Checklist/Cover Sheet until the resident responds to written notification of intent to certify and the results recorded thereon. The Unit Director shall advise Central Records to prepare and send the Notification of Intent to Certify Need for Continued Residential Care and Training and shall also forward the completed Plan of Care to Central Records;

(c) Central Records shall tentatively schedule the resident's hearing time before the State Training Center Review Board in one of the time slots allocated by the Review Board;

(d) Central Records shall complete the letter of Notification of Intent to Certify Need for Continued Residential Care and Training and forward it to the Superintendent or designee for signature. The letter of Notification of Intent to Certify Need for Continued Residential Care and Training shall contain all required items and be sent to recipients as described in paragraph (6)(a)(B) of this rule. The Unit Director or designee shall be responsible for explaining all items in the notification letter to the resident:

(A) If the resident agrees to certification, the Unit Director shall so designate on the place provided in the Checklist/Cover Sheet. If because of severe disability, the resident is unable to acknowledge the facility's notification of intent to continue residential care and training, the Unit Director or designee shall document this fact in the resident's central record and on the Checklist/Cover Sheet, which shall be conveyed to the State Training Center Review Board;

(B) If the resident objects to certification, the Unit Director shall complete action described in subparagraph (a)(E)(iv) of this section.

(e) Central Records shall determine that the Checklist/Cover Sheet is complete, keep a current list of those residents certified, procure the signature of the Superintendent or designee on the certification statement, finalize the resident's hearing time before the State Training Center Review Board, and forward the time and date of the hearing time with the resident's Plan of Care and appropriate supportive data for eligibility and need for continued residential care and training and the Checklist/Cover Sheet with signed certification to the secretary of the State Training Center Review Board for action;

(f) The facility shall provide transportation to the resident to attend the State Training Center Review Board hearing if needed, as requested by the resident, or at the Board's request;

(g) The facility shall provide staff at the State Training Center Review Board hearings to assist the resident if needed, as requested by the resident, or at the Board's request;

(h) The State Training Center Review Board shall approve or disapprove each resident's certification, check the corresponding approval or disapproval category on the Checklist/Cover Sheet, and forward the Checklist/Cover Sheet to the facility's Central Records;

(i) Central Records shall file each approved certification in the resident's central record, update the list of certified residents, and note and forward each disapproved certification to the Superintendent or designee;

(j) The Superintendent or designee shall cause each resident whose certification has been disapproved to be scheduled on the facility's Disposition Board agenda:

(A) The Disposition Board shall consider each resident whose certification has been disapproved and decide, after weighing the evidence, whether release is not in the best interest of the resident and whether commitment proceedings should be initiated pursuant to Chapter 683, Oregon Laws 1979. This decision, in the form of a recommendation, shall be forwarded to the Superintendent for approval or disapproval;

(B) The Superintendent shall evaluate the Disposition Board's findings and recommendation(s) regarding the resident whose certification has been disapproved by the State Training Center Review Board and shall approve or disapprove the recommendation(s):

(i) If the approved recommendation is discharge, the Superintendent shall direct Central Records and the resident's Unit Director to discharge the resident;

(ii) If the approved recommendation is commitment, the Superintendent shall direct Central Records to initiate commitment proceedings pursuant to Chapter 683, Oregon Laws 1979, codified as ORS 427.235 to 427.270, 427.280, and 427.285.

[ED. NOTE: Exhibits & Publications referenced are available from the agency.]

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 8-1979(Temp), f. & ef. 10-24-79; MHD 7-1980, f. & ef. 4-18-80

309-042-0035

Transfer and Discharge of Residents

(1) Purpose. This rule prescribes procedures for notifying certain specified persons:

(a) Before the transfer of a resident of a state training center for the mentally retarded to another Mental Health and Developmental Disability Services Division facility; and

(b) Before the discharge of a resident of a state training center for the mentally retarded. This rule also prescribes procedures for appealing transfers and discharges.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 430.041(1) and carries out the provisions of Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142).

(3) Definitions. As used in this rule:

(a) "Day plan" means a schedule of activities or programs provided for the resident leaving the state training center;

(b) "Discharge" means the permanent separation of the resident from the state training center. If the resident has been civilly committed, discharge also means termination of commitment. The term "release" is synonymous with discharge;

(c) "Disposition Board" means a body composed of administrative, clinical, and community consumer representatives appointed by the superintendent of the state training center to assess the release and/or discharge plans of residents before their return to the community and permanent separation from the state training center;

(d) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services;

(e) "Facility" means any Mental Health and Developmental Disability Services Division facility;

(f) "Living plan" means the residential arrangements provided for the resident leaving the state training center;

(g) "Qualified mental retardation professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401**;

(h) "Resident" means a person admitted to a state training center either voluntarily or after commitment to the Mental Health and Developmental Disability Services Division;

(i) "State institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton;

(j) "State Training Center" means Fairview Training Center; that part of Eastern Oregon Hospital and Training Center operated for the care, treatment, and training of mentally retarded persons; and any other facility operated by the Division for the care, treatment, and training of the mentally retarded;

(k) "State Training Center Review Board" means the Board created by Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142), codified as ORS 427.205;

(l) "Superintendent" means the executive head of Fairview Training Center and the executive head of Eastern Oregon Hospital and Training Center;

(m) "Transfer" means movement of a resident from one Mental Health and Developmental Disability Services Division facility to another Division facility for a good cause and in the best interest of the resident;

(n) "Unit" means a group of specified residential living areas, wards, cottages, or buildings within a state facility;

(o) "Unit Director" means a qualified mental retardation professional who is the administrative head of a designated living unit within a state training center;

(p) "Unit Interdisciplinary Team" means a group consisting of professional and direct care staff, usually including, but not limited to, representatives from social services, psychology, medicine, education, and direct care services. The team shall be chaired by the unit director. Its function is to prescribe the overall individual program for each assigned resident.

(4) General Description. The Division may transfer a mentally retarded person from one Mental Health and Developmental Disability Services Division facility to another, or discharge the person as no longer in need of residential care, treatment, or training, provided notification of such action is given to certain specified persons. The action may be appealed by those persons to the State Training Center Review Board, which will make its recommendation to the Administrator of the Division, or the Administrator's designee. The Administrator, or the Administrator's designee, shall make the final decision regarding transfer or discharge and notify, by certified mail, the person who appealed the action and the superintendent of the facility that requested the action.

(5) Procedure for Notification of Transfer and Appeal:

(a) The superintendent of the state institution shall determine the feasibility of transfer to another facility based upon the needs and best interest of the resident;

(b) Through established policy and procedure, the facility shall initiate a request to transfer the resident to another facility. If the resident is in imminent danger of doing serious bodily harm to self or others, and the facility cannot provide the necessary level of security to ensure the safety of the resident or others, the facility shall initiate a temporary transfer to the Forensic Psychiatric Service at Oregon State Hospital, pursuant to OAR 309-031-0010(5);

(c) If the transfer request is accepted by the superintendent of the facility and returned to the initiating facility, the initiating facility shall notify the resident and the resident's parent or guardian or the person entitled to custody of the transfer, in writing, 15 days before the date the transfer is to take place:

(A) The notice of transfer shall be sent by certified mail and include the following:

(i) Reason(s) for the transfer;

(ii) Name of the facility to which the transfer is being made;

(iii) Date of the transfer;

(iv) Right to appeal within ten days after receipt of the notice;

(v) Description of the appeals process; and

(vi) State Training Center Review Board's address and telephone number.

(B) The resident, with assistance of an assigned social worker, shall decide whether to object to the transfer and, if so decided, submit the resident's appeal in writing to the State Training Center Review Board within ten days after receipt of the notice of transfer;

(C) The facility shall transfer the resident on the date specified in the notice unless the transfer is appealed;

(D) The State Training Center Review Board shall notify the facility if a transfer has been appealed:

(i) The State Training Center Review Board shall hold a hearing at which Division staff, the resident being transferred or the resident's representative if the resident approves of the transfer, and the person making the appeal or the person's representative will be present to state the respective cases within 30 days from the date the appeal is received. The Board shall make a recommendation to the Administrator of the Division, or the Administrator's designee;

(ii) The Administrator, or the Administrator's designee, shall make a final decision and communicate it by certified mail to the person who appealed, with a copy of the letter to the superintendent of the facility that initiated the transfer.

(E) If a transfer is appealed, the initiating facility shall await the communication from the Administrator, or the Administrator's designee, and transfer or not transfer the resident, as directed.

(6) Procedure for Notification of Discharge and Appeal:

(a) The Unit Interdisciplinary Team of the Unit in which the resident resides shall make a recommendation of discharge to the state training center's Disposition Board when its assessment and evaluation have determined the resident is no longer in need of care, treatment, or training in a state training center;

(b) The Disposition Board shall consider the evidence for discharge, determine approval or disapproval of the Unit Interdisciplinary Team's recommendation, and forward this decision, in the form of a recommendation, to the superintendent;

(c) The superintendent shall approve or disapprove the Disposition Board's recommendation:

(A) If the discharge is approved, the superintendent shall direct the appropriate unit director to prepare and send a notice of discharge letter:

(i) The notice of discharge letter shall be sent to the resident and the resident's parent or guardian or the person entitled to custody, by certified mail, 15 days before the date the discharge is to take place;

(ii) The notice shall include:

(I) Reason(s) for the discharge;

(II) Statement of the proposed living plans and day plans for the resident after leaving the state training center;

(III) Date of the discharge;

(IV) Right to appeal with ten days of receipt of the notice;

(V) Description of the appeals process; and

(VI) State Training Center Review Board's address and telephone number.

(iii) The resident, with assistance of an assigned social worker, shall decide whether to object to the discharge and, if so decided, submit the resident's appeal in writing to the State Training Center Review Board within ten days after receipt of the notice of discharge.

(B) The facility shall discharge the resident on the date specified in the notice unless the discharge is appealed;

(C) The State Training Center Review Board shall notify the facility if a discharge has been appealed:

(i) The State Training Center Review Board shall hold a hearing at which Division staff, the resident being discharged or the resident's representative if the resident approves of the discharge, and the person making the appeal or the person's representative will be present to state the respective cases within 30 days from the date the appeal is received. The board shall make a recommendation to the Administrator of the Division, or the Administrator's designee;

(ii) The Administrator, or the Administrator's designee, shall make a final decision and communicate it by certified mail to the person who appealed, with a copy of the letter to the superintendent of the facility.

(D) Except as specified in paragraph (c)(E) of this section, if a discharge is appealed, the facility shall await the communication from the Administrator, or the Administrator's designee, and discharge or not discharge the resident, as directed;

(E) Any voluntary resident shall be discharged within 15 days of the resident's request for release regardless of whether the discharge is appealed, unless court commitment procedures are initiated under ORS 427.235 for continued residential care and training.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 430

Stats. Implemented:

Hist.: MHD 13-1979(Temp), f. & ef. 12-12-79; MHD 13-1980, f. & ef. 5-29-80

309-042-0050

Diagnosis and Evaluation Services

(1) Purpose. This rule prescribes standards and procedures for diagnostic evaluations of person known to be, or suspected of being, mentally retarded.

(2) Statutory Authority and Procedure. This rule is authorized by ORS 430.041(1) and carries out the provisions of ORS 427.104 as amended by Chapter 683, Oregon Laws 1979 (Enrolled Senate Bill 142).

(3) Definitions. As used in this rule:

(a) "Adaptive Behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for the age and cultural group;

(b) "Client" means the person known to be, or suspected of being, mentally retarded;

(c) "Diagnostic Evaluation" means the comprehensive assessment of a client to determine the extent of the developmental deficits, service(s) needed, and an action plan for intervention;

(d) "Intellectual Functioning" means functioning as assessed by one or more of individually administered general intelligence tests developed for that purpose;

(e) "Mental Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "**Manual on Terminology and Classification in Mental Retardation**" of the American Association on Mental Deficiency, 1977 Revision. Mental retardation is synonymous with mental deficiency;

(f) "Interdisciplinary Team" means a group of professionals that includes, but is not limited to, a psychologist, a social worker or social service worker, and a physician;

(g) "Physician" means a person licensed by the Board of Medical Examiners for the State of Oregon to practice medicine and surgery;

(h) "Psychologist" means a person possessing at least a master's degree in psychology from an accredited program with course work in human growth and development, tests, and measurement and a supervised practicum in individual psychological assessment, and/or a state certified school psychologist;

(i) "Severe Condition" means a condition that has continued, or can be expected to continue, indefinitely and contributes a substantial hardship to a person's ability to function normally in society;

(j) "Social Service Worker" means a person with a bachelor's or associate degree and at least three years of social work experience under the supervision of a qualified social worker, one year of which must be in work with the mentally retarded;

(k) "Social Worker" means a person with a master's degree in social work, or equivalent, and one year of experience in working with the mentally retarded.

(4) Procedure:

(a) Each diagnostic evaluation shall be done by an interdisciplinary team. Each member of the team shall assess the client individually and make a report according to the standards in this rule. Results of the diagnostic evaluation shall include a report that summarizes the client's diagnoses, problems, and the interdisciplinary team's recommendation;

(b) The summary report and all individual professional reports shall be forwarded to the appropriate service providers and/or referral source and to the community mental health program;

(c) When the diagnostic evaluation is performed in compliance with an order of the court, the summary report shall:

(A) Include a recommendation as to the type of treatment or training facility best suited to habilitate the client;

(B) Advise the court whether the client and, if the client is a minor or incapacitated, the client's parents or legal guardian would cooperate with voluntary treatment or training;

(C) State whether the client would benefit from voluntary treatment or training; and

(D) State whether the client would benefit from appointment of a legal guardian or conservator.

(5) Psychological Standards:

(a) A psychological assessment shall be done by a psychologist. The psychologist shall consider the client's intellectual functioning; adaptive behavior; sensory, perceptual, and motor development; speech and language skill; academic achievement; vocational skills; personality development; behavioral problems; and social development assessment;

(b) The psychologist shall report mental retardation and adaptive behavior impairments according to criteria established by the American Association on Mental Deficiency, 1977 Revision.

(c) The written psychological report shall include:

(A) Reasons for evaluation and prior evaluation history;

(B) Assessment procedures used;

(C) Behavior observation during evaluation;

(D) Current evaluation results and an interpretation of the results; and

(E) Recommendations regarding the client's program needs.

(6) Medical Standards:

(a) A medical assessment shall be done by a physician and shall include a history and a physical examination;

(b) The medical history shall include, to the extent available:

(A) Details of prenatal factors:

(i) Course of pregnancy;

(ii) Use of drugs; and

(iii) Hereditary disorders.

(B) Details of delivery (any complications).

(C) Immediate postpartum condition of the baby:

(i) Apgar;

(ii) Respiratory distress; and

(iii) Other.

(D) Postnatal history of illness and accident during early childhood; that is, cerebralinsults, encephalitis, dehydration, cerebral concussion, and other;

(E) Developmental landmarks;

(F) Seizure history;

(G) History of mental disorder;

(H) Family history;

(I) Present medications.

(c) The medical history may be taken by a qualified nurse or medical assistant;

(d) A standard physical examination will be completed and the results of the following shall be included in the examination record:

(A) Eye examination and other visual tests, as necessary;

(B) Ear examination and any necessary audiometry tests;

(C) Orthopedic evaluation;

(D) Coordination tests as necessary; and

(E) Brief neurological examination; that is, reflexes, muscle function, etc.

(e) The written report of examination shall include recommendations for medical care and treatment.

(7) Social Work Standards:

(a) During the diagnostic evaluation, the following information shall be obtained:

(A) Identifying information and legal status of the client;

(B) Reason for referral, the referral source, and name(s) of person(s) providing information, and relationship to the client;

(C) Description of client and presenting problems;

(D) Relevant history, specifically educational and vocational history and family data;

(E) Financial resources of the client, and, when relevant, financial resources of the client's family; and

(F) Social concerns and strengths of the client.

(b) The social work report shall contain interpretation of the information gathered under subsection (a) of this section, as well as recommendations.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 427 & 430

Stats. Implemented:

Hist.: MHD 12-1980, f. & ef. 5-5-80

Leaves of Absence for Residents

309-042-0060
Purpose and Statutory Authority

(1) Purpose. These rules establish policy and procedures for the temporary leave of absence and return of residents from the state training centers, and establish the process for reporting residents who are on unauthorized leave (UL) from state training centers.

(2) Statutory Authority and Procedure. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 427.041.

Stat. Auth.: ORS 427 & 430

Stats. Implemented:

Hist.: MHD 25-1982, f. 11-3-82, ef. 1-3-83

309-042-0065
Definitions

As used in these rules:

(1) "Central Record" means the principal individual case document for each resident that contains for safekeeping the pertinent clinical and programmatic data.

(2) "County of Commitment" means the governmental jurisdiction wherein the court is located which remanded the resident to the state training center.

(3) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 422.401** or as amended.

(4) "State Training Center" means Fairview Training Center; that part of Eastern Oregon Hospital and Training Center operated for the care, treatment and training of mentally retarded persons; and any other facility operated by the Division for the care, treatment, and training of the mentally retarded.

(5) "Superintendent" means the executive head of Fairview Training Center and the executive head of Eastern Oregon Hospital and Training Center.

(6) "Unit Interdisciplinary Team" means a group consisting of professional and direct care staff, usually including, but not limited to, representatives from social services, psychology, education, medicine, and direct care services. The team shall be chaired by a qualified mental retardation professional. Its function is to prescribe the overall individual program for each assigned resident. There is a Unit Interdisciplinary Team assigned to each cottage/ward.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 25-1982, f. 11-3-82, ef. 1-3-83

309-042-0070
General Description

The superintendent may grant a temporary leave of absence to residents of the facility. The state training center, the superintendent and the chief medical officer thereof, and the Administrator of the Mental Health and Developmental Disability Services Division, or designee, shall not be liable for a resident's expenses while on temporary leave of absence, nor shall they be liable for any damages whatsoever that are sustained by a person on account of the actions or misconduct of a resident while on leave of absence.

Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 25-1982, f. 11-3-82, ef. 1-3-83

309-042-0075
Policy

The superintendent of the state training center shall strongly encourage the use of authorized temporary leave of absence by residents in order to provide residents with community experiences, to strengthen ties with family and friends, provide respite from the state training center, and provide them with an opportunity for personal enjoyment.

Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 25-1982, f. 11-3-82, ef. 1-3-83

309-042-0080
Procedures

To carry out the policy stated in OAR 309-042-0075, the superintendent shall develop procedures for the facility which include, but are not limited to, the following:

(1) A description of temporary leave of absence categories:

(a) "Day Visit" means the resident is away from the facility's grounds for a period of time, but not overnight;

(b) "Vacation" means the resident is away from the facility's grounds for a specified period of time, at least overnight;

(c) "Preplacement Visit" means the resident is placed in a community residential setting prior to permanent community placement and discharge;

(d) "UL" means the resident is on unauthorized leave of absence from the facility; and

(e) "Other" means the resident is on a temporary leave of absence from the facility for the purpose of receiving specified treatment or training; for example, at the University of Oregon Health Sciences Center or at a local general hospital.

(2) Procedures for the release and return of residents which:

(a) Record the resident's release, both centrally and in the resident's living area;

(b) Obtain a signature from the person taking the resident on leave of absence, the person's address, telephone number, the person's relationship to the resident, and the date the resident is expected to return;

(c) Maintain a list of people approved to take individual residents out on temporary leave of absence and a list of restrictions, for applications as necessary, to protect certain specified residents and the community; and

(d) Provide a procedure for return from temporary leave of absence which insures that all areas of the facility needing to know, including the resident's living area, are notified of the time and fact of the resident's return and that the return is properly documented.

(3) Conditions for authorizing temporary leaves of absence:

(a) Residents may go on leave of absence with any person who has proper clearance. The following may be provided with such clearance to take residents out on temporary leave of absence:

(A) Parents or guardians without court or other restrictions;

(B) Persons with signed permission of parents or guardians; and

(C) Persons approved by the Unit Interdisciplinary Team and acceptable to the resident.

(b) Clearances are granted by, and subject to periodic review by the resident's Unit Interdisciplinary Team;

(c) Residents may sign themselves out on temporary leave of absence when approved by the resident's Unit Interdisciplinary Team;

(d) Certain persons may be restricted from taking residents out on temporary leave of absence for the following reasons:

(A) Parent or guardian has requested restriction; or

(B) Resident has requested restriction.

(e) Certain residents may be restricted from going out on temporary leave of absence, from time to time, by decisions of the resident's Unit Interdisciplinary Team. Residents may need to be restricted when they exhibit severe maladaptive behaviors which are considered dangerous to the resident or others, or which may have serious antisocial impact. Such restrictions with supporting reasons shall be documented in the resident's central record by a qualified mental retardation professional; and

(f) The status of residents under restriction shall be reviewed and updated at least within six months of the restriction or the date of the last review by the resident's Unit Interdisciplinary Team.

(4) A procedure for reporting of residents on unauthorized leave (UL) and their subsequent return to the facility which insure that:

(a) Thorough searches of the facility's grounds have been carried out before classifying the resident on UL status;

(b) When the grounds search has been concluded, and the resident is considered on UL status, the state and local police and the county of committment's community mental health program are advised of the following information by telephone to assist in returning the resident or to assure that the resident is safe and does not wish to return to the facility:

(A) Resident's name and case number;

(B) County of commitment, if applicable;

(C) Time last seen;

(D) Place, time and circumstances surrounding leaving, if known;

(E) A physical description of the resident including sex, age, height, weight, color of hair, color of eyes, wearing apparel when last seen, and other distinguishing characteristics;

(F) Name and address of nearest relative or guardian; and

(G) Whether the resident is considered dangerous; that is, has a history of aggressiveness to others, robbery, arson, etc. The fact of such reporting shall be documented.

(c) The State Fire Marshal is advised of the resident on UL status if the resident has a history of arsonous activities. The same information as given in subsection (4)(b) of this rule shall be given to the State Fire Marshal. The fact of such reporting shall be documented;

(d) Residents on UL status and considered dangerous are reported to the Mental Health Division as special incidents as prescribed in **Mental Health Division Management Media 3.000 and 3.002**. The time, date, and contacted person shall be recorded in the resident's record;

(e) The resident's nearest relative or guardian is contacted and the contact recorded; and

(f) The state and local police, State Fire Marshal if applicable, the resident's parent or guardian, and the mental Health Division, if applicable, are advised of the resident's return from unauthorized leave of absence (UL). The fact of such reporting shall be documented.

(5) A resident on UL from temporary leave of absence may be discharged from the facility if it is determined by the community mental health program and the Unit Interdisciplinary Team that the person is safe, has a satisfactory place to live and does not wish to return to the facility.

(6) These procedures must comply with the ICF/MR rule on Reserved Bed Payments (OAR 309-043-0080).

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 427 & 430
Stats. Implemented:
Hist.: MHD 25-1982, f. 11-3-82, ef. 1-3-83

309-042-0100
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures which govern the operation of the State Training Center Review Board, establish policy on the discharge or transfer of an individual from a state training center, and prescribe procedures for requesting a contested case hearing on a decision to transfer or discharge an individual from a state training center.

(2) Statutory Authority. These rules are authorized by ORS 430.041(1), 427.205(5) and 427.300(2).

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 7-1979(Temp), f. & ef. 10-10-79; MHD 4-1980, f. & ef. 4-3-80; MHD 8-1986(Temp), f. & ef. 9-12-86; MHD 10-1986(Temp), f. & ef. 10-2-86; MHD 2-1987, f. & ef. 3-30-87; MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97, Renumbered from 309-042-0025

309-042-0110
Definitions

As used in these rules, the following definitions apply:

(1) "Administrator" means the Administrator of the Mental Health and Developmental Disability Services Division.

(2) "Appropriate service alternatives" means:

(a) Residential services;

(b) Employment or alternatives to employment services; and

(c) Access to medical and dental services.

(3) "Best contemporary professional practices" means those services and systems designed to significantly increase the individual's independence, productivity, and integration.

(4) "Board" means the State Training Center Review Board.

(5) "Diagnosis and Evaluation Service" means the service established to provide or coordinate diagnostic evaluations before the placement of individuals with developmental disabilities in public or private training facilities.

(6) "Developmental disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy and/or other neurological handicapping condition which requires training or support similar to that required by individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18; and

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the person to function in society; or

(d) Results in significant sub average general intellectual functioning with concurrent deficits in adaptive behavior that are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiencies, 1977 Revision. Mental retardation is synonymous with mental deficiency.

(7) "Division" means the Mental Health and Developmental Disability Services Division.

(8) "Hearing case number" means a number assigned by the State Training Center Review Board to protect the confidentiality of individuals whose cases come before the Board.

(9) "Independence" means the extent to which persons with mental retardation or developmental disabilities exert control and choice over their own lives.

(10) "Individual" means a person who has been admitted to a state training center.

(11) "Integration" means use by persons with mental retardation or developmental disabilities of the same community resources that are used by and available to others and participation in the same community activities in which nondisabled persons participate, together with regular contact with nondisabled persons, and residence by persons with mental retardation or developmental disabilities in homes or in home-like settings which are in proximity to community resources, together with regular contact with nondisabled persons in their community.

(12) "Office of Developmental Disability Services" or "DD Office" means the Office of Developmental Disability Services of the Mental Health and Developmental Disability Services Division.

(13) "Productivity" means engagement in income-producing work by a person with mental retardation or developmental disabilities which is measured through improvements in income level, employment status or job advancement or engagement by a person with mental retardation or developmental disabilities in work contributing to a household or community.

(14) "State training center" means Fairview Training Center or Eastern Oregon Training Center.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0120
State Training Center Review Board Appointment and Terms of Office

(1) The Administrator shall appoint a Board composed of three members.

(2) Selection of Board. The Arc of Oregon, the Fairview Parent/Guardian Association and the Oregon Developmental Disabilities Council or their successor organizations may each recommend three persons to the Administrator. The Administrator may select one person from each list to serve as a member of the Board.

(3) Involvement and active interest. Each board member shall have had at least five years of involvement and active interest in programs for individuals with developmental disabilities.

(4) Employee of Division prohibited. No employee of the Division shall be a board member.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0130
Function of Board

Functions of Board. The Board shall perform the following functions:

(1) Annually review state training center certifications for continued residential care and training of individuals.

(2) Review appealed decisions of the Diagnosis and Evaluation Service regarding admissions to state training centers and advise the Administrator regarding the appropriateness of the admission; and

(3) Review appealed decisions of the state training centers regarding transfer or discharge of individuals and advise the Administrator regarding the appropriateness of such decisions.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0140
Staff Assistance, Legal Assistance and Official Address

(1) DD Office. The DD Office shall provide the Board with staff assistance and shall furnish or arrange for state training centers to furnish other services and supplies as may be needed by the Board.

(2) Legal assistance. The Administrator may arrange for the provision of legal services to the Board upon request.

(3) Mailing address. The official mailing address of the Board shall be: State Training Center Review Board, Office of Developmental Disability Services, 2575 Bittern Street NE, Salem, Oregon 97310.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0150
Chairperson Appointment and Duties

(1) Appointment. The Administrator may appoint one of the Board members to be the chairperson.

(2) Duties. The chairperson shall direct the activities and preside at all meetings of the Board.

(3) Absence of chairperson. The chairperson shall designate in their absence another member of the Board to be acting chairperson.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0160
Hearings

(1) Majority of board members required. The presence of a majority of Board members shall be required for the Board to conduct its statutory duties.

(2) Regular hearings. Regular hearings shall be held for the primary purpose of reviewing state training center certification for continued stay of individuals. Appeals as described in OAR 309-042-0190(1)(a) and (b) may be scheduled for hearing during regular hearings of the Board.

(3) Special hearings. Special hearings may be called by the chairperson as deemed necessary.

(4) Majority vote required for decisions. A decision of the Board shall require a majority vote of members present. In the event of a tie vote, the chairperson shall schedule a special hearing of the Board, within 30 days to resolve the tie vote.

(5) Conduct of hearings. The Board shall conduct hearings in accordance with the rules of order prescribed by the Board.

(6) Annual schedule of regular hearings. The Board shall publish and maintain an annual schedule of regular hearings. The schedule shall show the location, dates at each location, and the number of individual certifications the Board will hear on each date.

(7) Public notice of hearings. The distribution of the schedule and revisions thereof shall constitute public notice.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0170
Records

(1) Written minutes of hearings. Written minutes of each hearing shall be open to public inspection and shall include the following:

(a) Names of all Board members present;

(b) Results of the hearing, including the hearing case number used to identify individuals and applicants whose certification or appeal is considered by the Board; and

(c) In the case of a divided vote, the minutes shall record the vote of each Board member by name.

(2) Tape recording of hearings. All proceedings of the Board during closed portions of meetings shall be tape-recorded.

(3) Storage and confidentiality of tape recordings. All tape recordings shall be stored in a place and manner that protects their confidential nature.

(4) Written transcription of tape recordings. Written transcription of tape recordings shall not be made without just cause and without the specific written permission of the Administrator.

(5) Record retention. Records of Board Hearings will be retained in accordance with the State Training Center Review Board Rules of Conduct.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0180
Certification Hearings for State Training Center Individuals

(1) State training center annual review of plan of care and certification of continued stay. State training centers shall:

(a) Annually review the plan of care for each individual;

(b) Except as provided in OAR 309-042-0180(2), certify the individual's eligibility and need for continued residential care and training; and

(c) Present each certification with clear and convincing justification for continued residential care and training to the Board for its approval or disapproval.

(2) State training center certification or transfers of individuals under court commitment. State training center certification or transfers of individuals under court commitment pursuant to ORS Chapter 426 (Mentally Ill and Sexually Dangerous) or ORS 161.336 or 161.341 (Psychiatric Security Review Board) shall not be presented to, or considered by, the Board. Continued residential care and training of such individuals shall be determined by the Division, a court of appropriate jurisdiction or the Psychiatric Security Review Board as provided by law.

(3) State training center coordination of annual review and plan of care for individuals. The state training center shall coordinate its annual review of the plan of care for each individual with the schedule of regular hearings published by the Board so that the number of certifications for continued residential care and training approximates the number of certifications the Board indicates it will review on each scheduled hearing date.

(4) State training center responsibilities for notifications and forwarding of supporting documents. In advance of the regular hearings of the Board the state training center shall provide the Board with the name and case number of each resident it has scheduled for the Board to review at the hearing. The state training center shall also:

(a) Indicate which, if any, of those individuals that will be unable to be physically present at the Board hearing; and

(b) On or before the day of the Board hearing, forward to the Board the certification and supporting documents for each individual to be reviewed at the hearing.

(5) Assignment of hearing case number. The Board shall assign a hearing case number to each case that will be used to identify the individual in the minutes of the Board hearing.

(6) Certification hearings closed to the public. Because the hearing of certifications involve the consideration of records that are exempt from public inspection, such hearings shall be closed to the public.

(7) Board decisions based on determinations. The Board shall base its decision on the following three determinations:

(a) Whether the individual is eligible for a training center (IQ level and adaptive behavior);

(b) Whether the individual needs continued residential care and training; and

(c) Whether appropriate residential care and training for the individual is available in a community setting.

(8) Approval of certifications. If, in the opinion of the Board, the individual is by clear and convincing justification eligible for, and in need of, continued residential care and training and such services are not currently available in a community setting, the Board shall approve the certification.

(9) Certification disapprovals. If, in the opinion of the Board, the state training center has not presented the need for continued residential care and training with clear and convincing justification, the Board shall not approve the certification of the individual for continued care and training.

(10) Time limited approval of certification. At the hearing, the Board may grant a time-limited approval of certification up to 60 days upon its own motion in order to receive additional information from the state training center, or upon the request of the state training center in order to provide additional information, regarding the criteria described in OAR 309-042-0180(7)(a), (b) and (c). The Board may not grant a time-limited approval for any other reason or purpose. Prior to the expiration of the 60-day period, the Board shall reconvene the hearing and make a final decision to approve or disapprove certifications for the subsequent 10-month period.

(11) Programmatic or other concerns raised during hearing process. If in the course of a hearing the Board notes programmatic or other concerns affecting an individual that are unrelated to the criteria described in OAR 309-042-0180(7)(a), (b) and (c), the Board may request a response from the state training center. The request shall be in writing and on forms provided by the DD Office. The state training center shall issue its response to the Board within 60 days of receiving the request.

(12) Board hearing decisions. The Board's hearing decision shall be:

(a) Noted on the state training center certification over the signature of the chairperson or acting chairperson, one copy of which will be retained by the Board;

(b) Noted in the minutes of the hearing; and

(c) Communicated to the state training center within three working days following the hearing.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)

Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0190
Appeals of Admission of Individual

(1) Appeal rights. ORS 427.190 provides that an individual applying for admission to a state training center or an individual applying on behalf of a minor or incapacitated individual may appeal any decision of the Diagnosis and Evaluation Service regarding admission to the Administrator who will refer it to the Board.

(2) General appeal procedure. The appeal shall be in writing and shall set forth the reasons for the appeal.

(3) Appeal to the Board. Within 30 days of the receipt of the appeal, the Board shall:

(a) Schedule and hold the hearing before the Board;

(b) Notify the parties concerned of the time, place, and location of the scheduled hearing;

(c) Advise the individual making the appeal of their right to present their case;

(d) Assign a hearing case number that will be used to identify the individual or applicant for admission in the minutes of the Board hearing;

(e) Require the state training center or the Diagnosis and Evaluation Service to justify the decision under appeal; and

(f) After the hearing appeal, communicate in writing to the Administrator its recommendation as to disposition of the appeal. The recommendation to the Administrator shall be adopted by majority vote of the Board.

(4) Appeal hearings closed to the public. Because the hearing of appeals will involve the consideration of records that are exempt from public inspection, such hearings will be closed to the public, except as set forth in OAR 309-042-0190(5).

(5) Participants in an appeal hearing. The following individuals may attend the admission appeal hearing: representatives from the Division and the State Training Center, the individual and/or the individual's representative, the person making the appeal (if different from the individual), and/or his or her representative, and, for the duration of their testimony, witnesses.

(6) Final decision on appeal and notification. The Administrator shall make the final decision regarding the appeal and notify the appellant within 30 days of receipt of the Board's recommendation.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0200
Appeals of Discharge or Transfer of Individuals

(1) Appeals. ORS 427.300(2) provides that:

(a) The Division may, at any time, for good cause and in the best interest of the individual, transfer or discharge a resident as no longer in need of residential care, treatment or training in a state training center.

(b) At least 15 days prior to Division action, the Division shall notify the individual and the parent, guardian or person entitled to custody of the resident by certified mail of its decision.

(c) The notice shall indicate the right of the aforementioned parties to appeal this decision to the State Training Center Review Board in writing within 10 days after receipt of notice.

(d) The notice shall indicate the right of the aforementioned parties to a contested case hearing to appeal the Administrator's decision to transfer or discharge an individual. The Administrator's decision is made after receiving the recommendation of the State Training Center Review Board.

(2) Good cause exists for the transfer or discharge of an individual from a state training center under, but not limited to, the following circumstances:

(a) A plan to close the state training center where the individual resides is being implemented and appropriate service alternatives have been procured for the individual in the community as a condition for transfer or discharge; or

(b) The individual, or the individual's parent or guardian or person entitled to custody, requests transfer or discharge; or

(c) Appropriate services alternatives have been procured for the individual.

(3) It is in an individual's best interest to be more independent, integrated and productive, to live in a less restrictive environment, to receive services which are more consistent with the best contemporary practices, with preference given to community-based settings over institutional settings.

(4) The Division recognizes the individual, the parent, guardian or other person entitled to custody of the individual as key decision-makers in the development of any plan to transfer or discharge the individual from a state training center. For purposes of this rule, this recognition means the Division will closely consult with the individual, the parent, guardian, or other persons entitled to custody of the individual, and carefully consider their preferences expressed at each phase of the discharge or transfer planning process. In addition, during the planning process, the Division shall consider the following as part of the discharge or transfer planning process:

(a) The geographic proximity of the community residence to the family members and friends of the individual;

(b) The qualifications and training of the staff of the community service provider;

(c) The risk of mental and physical abuse of the individual;

(d) The availability of medical and dental services to sustain the health and well-being of the individual; and

(e) The availability of community-based services and activities appropriate to the mental and physical abilities of the individual.

(5) The following factors shall be considered in determining whether the transfer or discharge of an individual from a state training center is in the individual's best interest and shall be weighed and balanced in the context of each individual's proposed transfer or discharge:

(a) The effect of the transfer or discharge on the individual's independence, integration and productivity;

(b) The restrictiveness of the proposed service delivery environment; and

(c) The best contemporary professional practices in serving individuals with developmental disabilities.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0210
Appeal Rights

(1) Appeal Rights. The individual, the individual's parent or guardian or the person entitled to custody may appeal any decision of the Division to transfer or to discharge an individual from a state training center to the State Training Center Review Board.

(2) General appeal procedures. All appeals shall be in writing and mailed to the State Training Center Review Board, c/o MHDDSD. Upon receipt of an appeal, the Board shall direct the Division to suspend its decision to transfer or discharge the individual pending outcome of the appeal.

(3) Appeal to the Board. Within 30 days of the receipt of the appeal, the Board shall:

(a) Schedule and hold the hearing before the Board;

(b) Notify the parties concerned of the time, place and location of the scheduled hearing;

(c) Advise the individual making the appeal of their right to present their case; and

(d) Assign a hearing case number that will be used to identify the individual in the minutes of the Board hearing.

(e) After the hearing appeal, communicate in writing to the Administrator its recommendation as to the disposition of the appeal. The recommendation to the Administrator shall be adopted by majority vote of the Board.

(f) Appeal hearing closed to the public. Because the hearing of appeals will involve the consideration of records that are exempt from public inspection, such hearings will be closed to the public except as set forth in OAR 309-042-0210(3)(g).

(g) Participants in an appeal hearing. The following individuals may attend the discharge appeal hearing: representatives from the Division and the State Training Center, the individual and/or the individual's representative, the person making the appeal (if different from the individual), and/or his or her representative, and, for the duration of their testimony, witnesses.

(h) Final decision on appeal and notification. The Administrator shall make the final decision regarding the appeal and notify the appel-

lant by certified mail within 30 days of receipt of the Board's recommendation.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

309-042-0220
Rights of Review and Contested Case Hearings

(1) Request for Hearing. If, upon notification by certified mail of the Administrator's decision to transfer or discharge an individual from a state training center, the individual, the individual's parent or guardian, or the person entitled to custody of the individual disagrees with the Administrator's decision, he or she may request a contested case hearing before the Division. The request for a contested case hearing must be received by he Division in writing no later than ten calendar days from the date of service of the notice of the Administrator's decision to transfer or discharge an individual. The request for a contested case hearing shall include a short statement alleging why the transfer or discharge decision should be overturned.

(2) Hearing Rights. The contested case hearing shall be conducted in accordance with ORS 183.413 to 183.470.

(3) Prior to the scheduling of the contested case hearing, the Division shall offer the person requesting the contested case hearing an informal conference to review all available information and determine the need for a contested case hearing.

(4) Any person adversely affected or aggrieved by a final discharge or transfer order is entitled to a judicial review of the Order. Judicial review may be obtained by filing a petition of review within 60 days from the service of the order. Judicial review is pursuant to the provisions of ORS 183.482 to the Oregon Court of Appeals.

Stat. Auth.: ORS 430.041(1), 427.205(5) & 427.300(2)
Stats. Implemented: ORS 427.007, 427.205(5), 427.300(1) & 427.300(2)
Hist.: MHD 8-1996(Temp); f. & cert. ef. 12-10-96; MHD 5-1997, f. & cert. ef. 6-6-97

PROGRAMS FOR DEVELOPMENTAL DISABILITY SERVICES

DIVISION 43

INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED AND OTHER DEVELOPMENTALLY DISABLED PERSONS (ICF/MR)

309-043-0000
Purpose and Statutory Authority

(1) Purpose. These rules establish standards by which the Seniors and People with Disabilities Division approves payment for the delivery of services in Intermediate Care Facilities for Mentally Retarded and Other Developmentally Disabled Persons.

(2) Statutory Authority and Procedure. These rules are authorized by ORS 179.040 and 430.041 to carry out the provisions of Title XIX of the Social Security Act, and **42 CFR 483, Subpart I**. Rules and standards for capital-related costs shall be consistent with **42 CFR 413, Subpart G**, as amended and the General Rules of the Division of Medical Assistance Programs, OAR 410-120-1120 et seq.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90, MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0005
Definitions

As used in these rules:

(1) "Accrual Method of Accounting" means a method of accounting which recognizes revenues in the period when they are earned, regardless of when they are collected, and expenses in the period in which they are incurred, regardless of when they are paid.

(2) "Active Treatment" means a continuous program for each individual which includes aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

(a) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(b) The prevention or deceleration of regression or loss of current optimal functional status.

(3) "Administrator" means the administrator of an ICF/MR.

(4) "Area Agency on Aging" (AAA) means the designated entity with which the Seniors and People with Disablilities Division contracts to meet the requirements of the Older Americans Act.

(5) "Assistance Workers" means those workers in the locally designated SPD or AAA branch offices who determine financial eligibility.

(6) "Base Cost" means one of two major cost categories in the ICF/MR per diem reimbursement rate. Base cost consists of those expenses incurred in operating an ICF/MR minus the Labor Cost, which is the other major cost category.

(7) "Cash Method of Accounting" means a method of accounting which recognizes revenues only when cash is received, and expenditures only when cash is disbursed.

(8) "Change of Ownership" means a change in the entity which is responsible for the operation of an ICF/MR. Examples of events which change ownership include but are not limited to the following:

(a) Sole proprietor forms partnership; or
(b) Sole proprietor forms corporation; or
(c) Partnership is dissolved; or
(d) Partnership is incorporated; or
(e) Corporation is dissolved; or
(f) Corporation merges with another corporation; or
(g) Corporation consolidates with one or more other corporations to form a new corporation; or
(h) Joint venture is entered into by any two parties; or
(i) Joint venture is dissolved.

(9) "Compensation" means the total of all benefits and remuneration, regardless of the form, paid or claimed by an owner, or an administrator or assistance administrator, or any other employee. A determination of whether compensation is reasonable may involve consideration of, but is not limited to the following:

(a) Salaries paid or accrued;
(b) Supplies and services provided for personal use;
(c) Compensation paid by the facility to employees for the sole benefit of the owner;
(d) Fees for consultation, acting as director, or any other fees paid regardless of the label;
(e) Living expenses, including those paid for related persons.

(10) "Current Reproduction Cost" means the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to have built, reproduce in kind, or, in the case of equipment or similar assets, to purchase in the competitive market.

(11) "DD Case Manager" means county case managers who work with MR/DD clients and are employed by community mental health programs.

(12) "Developmental Disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy or other neurological handicapping condition which requires training or support similar to that required by, individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in case of mental retardation the condition must be manifested before the age of 18;
(b) Has continued, or can be expected to continue indefinitely;
(c) Constitutes a substantial handicap to the person's ability to function in society; and
(d) Results in significant subaverage general intellectual functioning with concurrent deficits in adaptive behavior which are manifested during the developmental period. Individuals of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the "**Manual of Terminology and Classification in Mental Retardation**" by the American Association on Mental Deficiency, **1983 Revision**. Mental retardation is synonymous with mental deficiency.

(13) "Diagnosis and Evaluation Services" "D & ES" means the service of the Department of Human Services created by ORS 427.104 to approve application for admission to state and private training centers; process and coordinate all placement of residents from state train-

ing centers and prior approve discharge plans from private training centers; consult on diagnostic evaluation statewide; provide information to the State Training Center Review Board, as appropriate; and provide consultation to appropriate agencies and individuals regarding person evaluated in Diagnosis and Evaluation Services.

(14) "Direct Care Staff" means the facility's living unit personnel who train residents in activities of daily living and in the development of self-help and social skills. This staff does not include nurses, housekeepers, maintenance or professional services included under active treatment services as defined in these rules.

(15) "Direct Care Staffing Ratio" means the staff ratios outlined in OAR 309-043-0190(2) and indicate the number of direct care staff that must be on duty in order to meet minimum staffing requirements over any given 24-hour period.

(16) "Division" means the Seniors and People with Disabilities Division of the Department of Human Services.

(17) "Facility" means an establishment which is licensed by the State to provide habilitative training and care to mentally retarded persons or persons with related conditions and certified by the State as an ICF/MR under Title XIX of the Social Security Act. The term "facility" applies to all classes of facilities certified as ICFs/MR, and to distinct parts of state institutions certified as ICFs/MR.

(18) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell. Usually, the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

(19) "Generally Accepted Accounting Principles" means accounting principles currently approved by the American Institute of Certified Public Accountants and other principles which have substantial authoritative support.

(20) "Goodwill" means the excess of the price paid for a business over the fair market value of all identifiable, tangible and intangible assets of that business.

(21) "Historical Cost" means the actual cost incurred by the present owner in acquiring and preparing an asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. It does not include "start-up costs" as defined in this rule. For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or the fair market value of the asset at the time of its purchase.

(22) "ICF/MR Cost Statement" means a report of the facility's revenues, expenses, assets and liabilities.

(23) "Individual Program Plan (IPP)" means a written plan for each resident which includes both short- and long-range goals which can be measured in terms of the resident's habilitation and progression from dependent to independent functioning.

(24) "Interdisciplinary Team (IDT)" means the group representing the professions, disciplines or service areas that are relevant to identifying the individual's needs; appropriate facility staff; the individual; parents of the individual (if the individual is a minor) or the individual's legal guardian; and other agencies serving the individual convened to review and plan aspects of the resident's treatment. Each participant in the preliminary evaluation and/or Individual Program Plan process utilize the skills, competencies, insights and perspectives of his or her particular training and experience to focus on identifying the developmental needs of the resident and to devise ways to meet those needs. At least one member must be a Qualified Mental Retardation Professional. Participants share and discuss on a face-to-face basis all information and recommendations in order to develop a total unified and integrated treatment plan: Prior to the Team meeting, each participant must:

(a) Determine the resident's current development status;

(b) Identify developmental problems that should be ameliorated;

(c) Develop steps that should be attained next; and

(d) Propose ways of reaching those objectives.

(25) "Interim Per Diem Reimbursement Rate" means a temporary per diem rate used to reimburse ICFs/MR before the per diem reimbursement rate is established for the year-end settlement.

(26) "Labor Cost" means a major cost category used in computing the per diem in the reimbursement rate broken down into the following areas:

(a) Administrative Salaries;

(b) Other Administrative Salaries;

(c) Nursing Services;

(d) Direct Care Staff;

(e) Other Salaries;

(f) Active Treatment Services;

(g) Payroll Taxes;

(h) Employee Benefits.

(27) "Medicaid Specialist" means the Medicaid Specialist in the Developmental Disability Services Office of the Division.

(28) "Mental Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered mentally retarded if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **Manual on Terminology and Classification in Mental Retardation** of the **American Association on Mental Deficiency, 1983 Revision**. Mental retardation is synonymous with mental deficiency:

(a) "Adaptive Behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for age and cultural group;

(b) "Developmental Period" means the period of time between birth and the 18th birthday;

(c) "Intellectual Functioning" means functioning as assessed by one or more of the individually administered general intelligence tests developed for that purpose;

(d) "Significantly Subaverage" means a score on the test of intellectual functioning that is two or more standard deviations below the mean for the test.

(29) "Model Budget Rate" means an interim rate calculated for each Small Residential Training Facility and Large Residential Training Facility according to OAR 309-043-0030(1)(a) and (b) and 309-043-0185(1)(a). The rate establishes a reasonable cost ceiling for economically and efficiently operated ICFs/MR.

(30) "Necessary" means the services or goods purchased that are required by law, prudent management, and for the normal operation of an ICF/MR or related business.

(31) "Net Per Diem Cost" means one of the alternative interim rates calculated for SRTFs and LRTFs according to OAR 309-043-0185(1)(b).

(32) "Division of Medical Assistance Programs" (OMAP) means the Division of the Oregon Department of Human Services responsible for the coordination of medical assistance programs within the State of Oregon.

(33) "Preliminary Evaluation" means a written comprehensive, interdisciplinary professional evaluation of the client. The evaluation should be prepared prior to the client applying for Title XIX reimbursement in an ICF/MR. The evaluation must: contain background information; current, valid assessments of the individual's functional, developmental, behavioral, social, health and nutritional status; determine that the individual requires active treatment, the facility can provide for the individuals' needs, and admission is likely to benefit the individual.

(34) "Qualified Mental Retardation Professional (QMRP)" means a person who meets the qualifications of **42 CFR 483.430**. Each facility must have at least one QMRP.

(35) "Reasonable Charge or Cost" means the consideration given is equal to an amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(36) "Related Organization" means an entity which, to a significant extent, is under common ownership and/or control with, has control of or is controlled by the contractor. An entity is deemed to "control" another entity if it has a five percent or more ownership interest in the other, or if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(37) "Residential Classification Instrument (RCI)" means an assessment tool developed by the Seniors and People with Disabilities Division to help providers determine the skill level of mentally retarded/developmentally disabled persons. The RCI is required to deter-

mine the resident's classification. The RCI must be completed as part of the annual Individual Program Plan to determine the resident's classification.

(38) "Reserve Bed" means a bed that is unoccupied due to an individual's temporary absence from the facility for a home visit, community based habilitative experience, or hospitalization.

(39) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement or direction by the donor to a specific purpose.

(40) "SPD" means the Seniors and People with Disabilities Division of the Department of Human Services.

(41) "Start-Up Costs" means the one-time pre-opening costs (except Certificate of Need cost which is not included) incurred from the time preparation begins on a newly constructed or purchased building until the first ICF/MR resident is admitted. Startup costs include administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. Architects' fees and similar costs, which are part of the historical cost of the facility, are not included.

(42) "Straight-Line Depreciation." Under the straight-line method of depreciation, the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(43) "Title XVIII" means Title XVIII of the Social Security Act.

(44) "Title XIX" means Title XIX of the Social Security Act.

(45) "Uniform Chart of Accounts" means a list of account titles identified by code numbers established by the Division for providers to use in reporting their revenues, expenses, assets and liabilities. Each Full Service Residential Training Facility (FSRTF) will use the list of account titles and cost codes provided in the Medicare (Title XVIII) cost report form number 2552.

(46) "Useful Life" means the depreciable asset's normal operating or service life to the provider, subject to the provisions of **42 CFR 413.134(b)(7)(i)**. Factors to be considered in determining useful life include normal wear and tear; obsolescence due to normal economic and technological changes; climatic and other local conditions; and the provider's policy for repairs and replacement.

(47) "Vacant Bed" means a bed that is unoccupied due to an individual's permanent discharge from the facility.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 10-1985, f. & ef. 6-13-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0010
Conditions for Payment

In order for a facility to receive reimbursement from the Division for Title XIX ICF/ MR services, the following conditions must be met:

(1) The state has certified that the facility meets federal certification requirements.

(2) The facility is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, the Age Discrimination Act of 1975 as amended, the Americans with Disabilities Act of 1990 as amended, and any other applicable federal and state laws.

(3) A signed agreement specifying the facility class has been entered into between the Division and the facility.

(4) It has been determined by the Division that the Medicaid (Title XIX) residents are admitted, discharged and receive care in accordance with these rules as evidenced by facility records.

(5) Payment shall not be made for educational program services or vocational rehabilitation services except as allowed in **42 CFR Parts 441.13**.

(6) Payment will be made based on the Division's prior determination of the class of a facility. When a change in class occurs because of a new determination by the Division or for another reason, such as resulting from the facility's successful appeal, payment will be limited as follows:

(a) From the start of a fiscal year until the last day the former classification is effective, payment will be made as determined under these rules for the facility while in the former classification;

(b) From the date the new classification is effective until the end of the fiscal period, payment will be made as determined under these rules for the facility while in the new classification;

(c) The classification becomes effective on the date the Division Administrator or designee certifies a facility meets criteria specified in OAR 309-043-0030.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-18; MHD 8-1981, f. & ef. 12-11-81; MHD 4-1984, f. & ef. 8-1-84; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0015
Limitations

(1) Limitation of agreements and certification:

(a) New agreements to provide services as an ICF/MR shall be entered into by the Division only with facilities which:

(A) Had agreements with the Children, Adults and Families Division (AFS) as of May 24, 1978 to provide services as an ICF/MR; or

(B) Are licensed as a Nursing Home for the Mentally Retarded or General Hospital or Residential Training Facility, Center or Institution and certified as a ICF/MR.

(b) In addition to subsection (1)(a) of this rule, the Division may refuse to enter into new agreements with facilities which do not have an identified potential resident occupancy of at least 95 percent of their licensed bed capacity. The 95 percent potential occupancy may be made up of any combination of non-Title XIX and Title XIX clients. For Title XIX clients, the facility must submit the following documentation to the DD Medicaid Specialist at the Division:

(A) Client's name, address and CAF case number; and

(B) A copy of the Salem D & ES's prior authorization of payment for ICF/MR services.

(2) Limitation on payment for ICF/MR certified beds. The Division shall limit payment for care in an ICF/MR to the number of beds authorized by action of the Legislature Emergency Board.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0020
Resident Eligibility and Admission

(1) The Division shall determine client eligibility for ICF/MR services after receipt of the following information:

(a) A preliminary interdisciplinary professional evaluation;

(b) A written evaluation by the DD Case Manager regarding the alternative resources available to the client in the home, family and community;

(c) An explicit recommendation with respect to the need for admission or, in the case of residents who make application while in a facility, the need for continued care in such facility. Where it is determined that care in a facility is required by a resident whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record and plans initiated for the active exploration of alternatives.

(2) Payment for care provided by a facility must be prior authorized by the Division. The DD Case Manager shall make a referral to the Division's Salem D & ES Unit for prior authorization of payment. The referral must include the information listed in subsection (1)(a) of this rule:

(a) Prior to requesting payment, the facility must develop an initial Individual Program Plan which includes:

(A) Diagnosis, symptom(s), complaint(s), and/or complications indicating the need for admission;

(B) A description of the functional level of the resident;

(C) Written objectives, orders (as appropriate) for services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and

(D) Plans for continuing care including provisions for review and necessary modifications of the plan and discharge.

(b) Authorization of payment will be based upon the evaluation material and recommendations and criteria outlined in federal regulations relating to Title XIX Services;

(c) Written reports of the preliminary evaluation and the written initial Individual Program Plan must be entered into the resident's record at the time of admission, or in the case of residents already in the facility, immediately upon completion;

(d) Receipt of the financial planning form from the Assistance Worker shall confirm the resident as eligible to receive Title XIX ICF/MR reimbursement services.

(3) Upon request, the facility shall grant the Division access to facility records pertaining to Medicaid residents.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0025
Plan of Care and Utilization Review

(1) Individual Program Plan:

(a) Annually, within 365 days, the facility's Interdisciplinary Team must review the individual's comprehensive functional assessments and IPP for relevancy and update as necessary. Representatives of relevant professions, disciplines, or services; the client; and the legal guardian or parent (if the client is a minor) must participate in the review process. One member of the team must be the resident's QMRP;

(b) A facility must provide in a protected residential setting, individualized on-going evaluation, planning, continuous 24-hour supervision, coordination and integration of health and habilitative services to help each resident reach his or her maximum functioning capabilities. The Individual Program Plan shall be in writing and shall:

(A) Identify client needs as described by the comprehensive functional assessments; describe programs that meet the client's needs; state specific objectives necessary to meet the client's needs; state the planned sequence for dealing with those objectives;

(B) State each objective separately in terms of a single behavioral outcome; assign projected completion dates to each objective; express each objective in behavioral terms that provide measurable indices of performance; organize objectives to reflect a developmental progression appropriate to the individual; and assign priorities to each objective.

(c) Annual Review. At least annually, an IDT including professions, disciplines, and services involved in carrying out the resident's Individual Program Plan shall re-evaluate the plan. Re-evaluation includes review of the resident's progress toward meeting the plan objectives, review and update of the comprehensive functional assessments, review and update of the appropriateness of the Individual Program Plan, assessment of continuing need for institutional care, and consideration of alternate methods of care.

(2) Utilization Review. All ICF/MR Utilization Review shall be done by the Division.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0030
Classes of ICF/MR Facilities and Residents

(1) Classes of ICFs/MR. The State of Oregon has established the following three classes of ICFs/MR based upon classification of residents, size of the facility, and staffing requirements:

(a) "Small Residential Training Facility (SRTF)" means a facility having 15 or less beds and providing active treatment in a Title XIX certified facility;

(b) "Large Residential Training Facility (LRTF)" means a facility having from 16 to 199 beds that provides active treatment in an intermediate care facility under Title XIX regulations. The LRTF model budget may be applicable to a small residential training facility (SRTF) which is constructed and programmed to serve residents who are not capable of self-preservation in emergency situations;

(c) "Full Service Residential Training Facility (FSRTF)" means a facility having 200 or more certified ICF/MR beds providing the full range of active medical and day treatment services required in state and federal rules and regulations:

(A) The facility may be less than 200 beds if it meets all of the following criteria:

(i) It is certified ICF/MR and is licensed as a nursing home for the mentally retarded;

(ii) It serves a high percentage of clients who are non-ambulatory, medically fragile or in some other way seriously involved;

(iii) Its location is such that professionals with a knowledge of the medical and dental needs of people with severe mental and physical handicaps are not generally available and must be hired as permanent staff; and

(iv) It serves any and all clients referred by the Mental Health and Developmental Disability Services Division.

(B) The Division has the option of approving only classification changes that do not increase the total number of Full Service Residential Training Facility beds in the state.

(2) Classes of ICF/MR Residents:

(a) The State of Oregon has established the following three classifications of residents in ICFs/MR which are determined by use of the Division's Resident Classification Instrument:

(A) Class "A" includes any of the following:

(i) Children under six years of age;

(ii) Severely and profoundly retarded residents;

(iii) Severely physically handicapped residents; and/or

(iv) Residents who are aggressive, assaultive or security risks, or manifest severely hyperactive or psychotic-like behavior.

(B) Class "B" includes moderately mentally retarded residents requiring habilitative training;

(C) Class "C" includes residents in vocational training programs or sheltered employment. The training programs or work situations for Class "C" residents must be an integral part of the resident's active treatment program and be clearly documented in the resident's Individual Program Plan.

(b) The "A," "B," or "C" classification of each resident shall be determined by the facility administering the Resident Classification Instrument (RCI) for the ICF/MR Program within 30 days after the resident is admitted to the facility;

(c) The RCI shall be administered annually as part of the resident's annual Individual Program Plan;

(d) RCIs shall be furnished by the Division;

(e) Except for FSRTFs, the facility shall prepare a monthly report stating the current classification of each resident and shall submit with the Cost Statement a report indicating the number of resident days by classification by month.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 4-1984, f. & ef. 8-1-84; MHD 10-1985, f. & ef. 6-13-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0035
Rates

(1) The daily rate of payment for Oregon facilities, and out-of-state facilities in areas contiguous to Oregon which accept Oregon residents on a regular basis, shall be the individual rate established by the Division for that facility based on an audit of the facility's ICF/MR Cost Statement. The Division will audit the Cost Statement, make necessary adjustments; establish the individual daily rate(s) for that facility; and certify the established daily rate(s) to the facility.

(2) Facilities in Oregon and in areas contiguous to Oregon which provide 1,000 or fewer days of care to Oregon residents during the facility's reporting period need not file an ICF/MR Cost Statement. The Division will pay Oregon facilities 95 percent of the facility's public billing rate for up to 1,000 resident days. Payment to facilities in areas contiguous to Oregon which meet this criteria shall be made as described in section (3) of this rule.

(3) Rates for facilities described in section (2) of this rule and for out-of-state facilities in areas not contiguous to Oregon shall be made at 95 percent of the facility's public billing rate providing:

(a) The facility files with the Division its Medical Vendor Certification, certifying its Title XIX rate and its compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended, the Americans with Disabilities Act of 1990 as amended, and any other applicable federal and state laws;

(b) Payment does not exceed the highest rate established by the Division for ICF/MR facilities in the State of Oregon;

(c) Oregon residents will be returned to Oregon when proper placement can be made and it is possible to do so.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:

Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90, MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0040
Cost Allocation

(1) Full Service Residential Training Facilities shall use Medicare cost allocation methods.

(2) Except as provided in section (1), (3), (4), or (5) of this rule the allowable cost per day for each facility shall be allocated as designated below: Cost Area — Allocation Method:

(a) Administrative Salaries — Resident Days;
(b) General and Administrative — Resident Days;
(c) Shelter — Square Footage;
(d) Utilities — Square Footage;
(e) Laundry — Resident Days;
(f) Housekeeping — Square Footage;
(g) Dietary — Resident Days;
(h) Nursing Salaries — Actual Payroll;
(i) Nursing Supplies and Services Resident Days;
(j) Return on Equity — Resident Days;
(k) Other Salaries — Actual Payroll;
(l) Direct Care Salaries — Actual Payroll;
(m) Active Treatment Services — Actual Payroll.

(3) If the ICF/MR can demonstrate to the Division's satisfaction that a different allocation method is more reasonable and accurate, the different allocation may be used in lieu of the designated method.

(4) Where costs are non-resident related, the ICF/MR shall use an appropriate allocation method to reasonably and accurately allocate costs.

(5) If the Division finds that it is more reasonable and accurate to use a different method than specified in section (1) of this rule for a given ICF/MR, such allocation method shall be used.

(6) When a facility has designated areas for providing more than one level of care or type of care, costs shall be allocated to each of those designated areas.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0045
All-Inclusive Rate

(1) Definition. Reimbursement by the Division constitutes payment in full for ICF/MR services. The rate established for an ICF/MR includes reimbursement for all services, supplies, and facility equipment required for care, by state and federal standards except the following:

(a) Medical care or services by outside providers paid separately through other Title XIX Medical Assistance funds, Title XVIII, Veterans Administration, etc.; and

(b) Personal incidental items authorized for payment from the resident's personal incidental allowance; and

(c) Donations as provided in OAR 309-043-0145.

(2) Inclusions. The following types of items and services are included in the all-inclusive rate (The fact that the provider may customarily make a separate charge to private residents is irrelevant.):

(a) All care or services except as specified in OAR 309-043-0170, including restorative nursing care;

(b) Room, board and laundry (including laundry of residents' bedding and clothing whether performed by the facility or an outside provider);

(c) Items which are routinely furnished to all residents without additional costs;

(d) Items stocked by the facility in gross supply and administered individually on physician's order;

(e) Items owned or rented by the facility which are utilized by individual resident but which are reusable and expected to be available in a facility;

(f) Non-prescription, non-legend, over-the-counter pharmaceuticals not listed in Division of Medical Assistance Programs' "**Guide for Pharmaceutical Services**";

(g) Shaves, haircuts, and shampoos as required regularly for cleanliness must be provided by the facility. These are included in the all-inclusive rate whether performed by facility staff or outside providers;

(h) All medical services, drugs and supplies except as provided in OAR 309-043-0170.

(3) Examples. The all-inclusive rate established for the facility includes but is *309-043-0105* limited to:

(a) Services and Programs:

(A) Professional services as provided in OAR 309-043-0050 and 309-043-0095;
(B) Activity and therapeutic recreational programs;
(C) Behavioral management;
(D) Basic home living skill training;
(E) Social skill training;
(F) Sex education;
(G) Self help skill training;
(H) Hand feeding;
(I) Incontinency care;
(J) Management of personal incidental funds;
(K) Massages (by nursing staff);
(L) Reality therapy;
(M) Restorative aids;
(N) Special diets;
(O) Tray service;
(P) Vehicles maintained by facility for transportation of residents or to conduct facility business;
(Q) Community survival skills;
(R) Dental consultation services beyond what is paid for by DMAP "**Title XIX Dental Care Provider Guide**";
(S) Secure treatment;
(T) Restorative Nursing Care;
(U) Assistive hearing devices.

(b) Supplies:

(A) Air mattresses;
(B) Airway-oral;
(C) Alternating pressure pads;
(D) Applicators, cotton tipped;
(E) Aquamatic K pads (water-heated pad);
(F) Arm slings;
(G) Bandages, including elastic or cohesive;
(H) Basins;
(I) Bed frame equipment (for certain immobilized bed patients);
(J) Bedpad, regular and fracture;
(K) Bed rails;
(L) Bibs, including plastic;
(M) Canes;
(N) Catheter (any size, including indwelling);
(O) Catheter bags, plugs and tray;
(P) Clinitest tablets;
(Q) Colon tubes;
(R) Colostomy bags (including those with special rings or seals, such as a karaya seal);
(S) Cotton and cotton balls;
(T) Crutches;
(U) Decubitus ulcer pads;
(V) Deodorants, room;
(W) Disposable underpads;
(X) Douche bags;
(Y) Drainage bags, sets, tubes;
(Z) Dressings (all, including surgical and dressing trays, pads, tape, sponges, swabs, etc.);
(AA) Enemas and enema supplies;
(BB) Eye pads;
(CC) Feeding tubes and units, gastric, nasal;
(DD) First aid supplies;
(EE) Flotation mattresses, pads and/or turning frames;
(FF) Folding foot cradle;
(GG) Food and food substitutes;
(HH) Food provided between meals for supplemental nourishment;
(II) Footboards;
(JJ) Gauze and gauze sponges;
(KK) Geriatric chairs;
(LL) Gloves, unsterile and sterile, examination and surgical;
(MM) Gowns, hospital;

(NN) Heat cradle;
(OO) Heat pads;
(PP) Heel protector;
(QQ) Hot pack machine;
(RR) Hot water bottles;
(SS) Ice bags;
(TT) Ileostomy bags;
(UU) Incontinency care and supplies, pants, diapers;
(VV) Infusion arm boards;
(WW) Inhalation therapy supplies: Aerosol inhalators, self-contained; Aerosol (other types); Nebulizer and replacement kit; steam vaporizer;
(XX) Intermittent positive pressure breathing apparatus;
(YY) (I.P.P.B.);
(ZZ) Invalid ring;
(AAA) Irrigation bulbs and trays;
(BBB) I.V. trays and tubing;
(CCC) Jelly, lubricating;
(DDD) Karaya rings;
(EEE) Lamps, infrared and ultraviolet;
(FFF) Laxative, proprietary;
(GGG) Linens, extra;
(HHH) Lotions and oils;
(III) Medicine dropper;
(JJJ) Nasal cannula;
(KKK) Nasal catheter;
(LLL) Nasal tube feeding;
(MMM) Needles (various sizes);
(NNN) Overhead trapeze equipment;
(OOO) Oxygen;
(PPP) Oxygen tents, masks, etc.;
(QQQ) Padding for incontinent care;
(RRR) Pumps, aspiration and suction;
(SSS) Restraints;
(TTT) Rubber rings;
(UUU) Sand bags;
(VVV) Sheepskin;
(WWW) Soap, including medicated;
(XXX) Specimen cups and bottles;
(YYY) Stomach tubes;
(ZZZ) Suction equipment and machines;
(AAAA) Syringes (all sizes) reusable and disposable;
(BBBB) Tes-tapes;
(CCCC) Thermometers;
(DDDD) Tissues, bedside and toilet;
(EEEE) Tongue depressors;
(FFFF) Traction equipment;
(GGGG) Tuberculin tests;
(HHHH) Urinals, male and female;
(IIII) Urinary tube and bottle;
(JJJJ) Urological solutions;
(KKKK) Walkers;
(LLLL) Water Pitchers;
(MMMM) Wheelchairs (see OAR 309-043-0060).

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0050
Payment for Medical Care and Services

(1) Legend drugs and biologicals. Except as provided in section (5) of this rule legend drugs and biologicals provided to a resident as prescribed by a licensed physician are not included in the all-inclusive rate. Payment for such drugs is made directly to the licensed pharmacy by DMAP under the rules, regulations, and billing procedures as set forth in DMAP's "**Guide for Pharmaceutical Services**." Resident's personal funds are not to be used for drugs and biologicals which can be furnished under the DMAP "**Guide for Pharmaceutical Services**."

(2) Influenza injections. Except as provided in section (5) of this rule injections for the prevention of influenza will not be paid by the Division on a blanket basis for all residents in the facility. The Division will give consideration to providing injections on an individual basis when justified by the Drug Exception Procedures set forth in the DMAP "**Guide for Pharmaceutical Services**."

(3) X-ray and laboratory. Except as provided in section (5) of this rule, x-ray and laboratory procedures, provided in or out of the facility, are not included in the all-inclusive rate.

(4) Oxygen. Except as provided in section (5) of this rule, a separate supply of oxygen for a "heavy user," positive-pressure apparatus and/or respirator used solely by an individual resident, prescribed by a licensed physician, are not included in the all-inclusive rate. Payment must be prior authorized by the locally designated SPD or AAA branch office and will be made directly to the ICF/MR at fees authorized by DMAP. A "heavy user" of oxygen is defined as a client whose oxygen need is expected to exceed an average of 1,000 liters per day in any month:

(a) Payment will be made directly to the ICF/MR when oxygen is "piped-in" and metered *if* the resident, lacking the "piped-in" oxygen, would require his own individual bedside tank. The amount of oxygen given to the resident must be accurately metered and measurable to the resident, and the oxygen must always be available to the resident. The metered amount of oxygen and dates used must be reported by the ICF/MR on the Medical Service Authorization and Invoice, as justification for payment;

(b) If a Title XIX client requires only periodic oxygen (on a PRN basis), rather than a separate supply to meet the needs of a heavy user, it will be supplied as a "house" item, either by cylinder or "piped-in." The cost of oxygen and positive-pressure apparatus and/or respirator will be included in the all-inclusive rate.

(5) Full service residential training facilities (FSRTF). FSRTF will include all medical services, oxygen, drugs and supplies, including x-ray and laboratory procedures, provided in the facility in their all-inclusive rate.

(6) Outside provider payment. When not included in the per diem rate, payment will be made directly to the physician or other provider of medical care by DMAP according to the appropriate DMAP fee schedule established for that service.

(7) Medical transportation:

(a) Costs incurred for medical transportation are included in the all-inclusive rate when provided in the facility's own vehicle, and are not when provided by a third-party carrier. Payment for medical transportation by a third-party carrier is made by DMAP to the carrier as provided in DMAP's "**Medical Transportation Guide**";

(b) The DD Case Manager is responsible for arranging all medical transportation plans utilizing third-party carriers. The carrier is determined by the resident's condition, distance to the medical facility and frequency of the trip. The least expensive mode of transportation will be utilized consistent with these conditions:

(A) Payment for medical transportation by a third-party carrier must be prior authorized by the DD Case Manager. Reasonable notice must be given by the facility to the DD Case Manager when non-emergency medical transportation is requested;

(B) Emergency medical transportation, provided by a third-party carrier when the DD Case Manager's authorization of payment cannot be immediately obtained, must be reported to the DD Case Manager as soon as feasible (but not later than the next working day) and an assessment of medical need will be made prior to payment.

(c) Cost to the facility for medical transportation provided in the vehicle of a facility employee will be included in the ICF/MR Costs Statement, Medical Transportation, as part of the all-inclusive rate. These costs must be documented by mileage figures and employee identification;

(d) Travel expense is limited to lesser of actual cost or current year IRS mileage allowance. Public transportation expense is allowable at cost.

(8) Sterilization, abortion, and hysterectomy. The DMAP "**Physician's Service Guide**" sets forth the conditions and process for which payment will be made.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0055
Non-Medical Transportation

(1) Transportation for non-medical services in a facility's own vehicle to carry out a resident's training program or to carry out the facility's business is included in the all-inclusive rate.

(2) Cost to the facility for transportation related to carrying out a resident's training program or to carry out the facility's client-related business and provided in the vehicle of a facility employee will be included in the ICF/MR Cost Statement, Travel — Non-Medical, as part of the all-inclusive rate. These costs must be documented by mileage figures and employee identification.

(3) Transportation for residents on leave of absence from the facility shall be the responsibility of the resident or the facility (see OAR 309-043-0080). This expense is *not* included in the all-inclusive rate, even though the leave may be part of the resident's Individual Program Plan.

(4) Non-medical out-of-state transportation costs are not included in the all-inclusive rate.

(5) Private use of the facility's vehicle is not an allowable cost.

(6) Travel expense is limited to the lesser of actual cost or current year IRS mileage allowance. Public transportation is allowable at cost.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0060
Personal Incidental Funds (PIF)

(1) Each Title XIX resident is allowed to retain a specific monthly amount of income for personal needs. These personal needs include such items as clothes, tobacco, or other day-to-day incidentals. This monthly allowance is *not* to be applied toward the resident's cost of care. Generally, the source if income for personal needs is Social Security, veterans benefits, private income, Public Welfare or Supplemental Security Income (SSI):

(a) Assistance workers use the amount of a resident's income to determine:

(A) Initial eligibility for Title XIX;

(B) Amount of income and other resources which must be applied toward the resident's cost of care; and

(C) Amount of income and other resources which can be retained by the resident.

(b) Assistance workers are required to perform an annual review to determine if a resident's total funds are within the maximum allowed for Title XIX eligibility. Excess amounts shall be applied to the cost of care;

(c) The DD Case Manager must review the resident's PIF at least annually to ensure appropriate use of the funds.

(2) Allowable items. The following personal incidental items, supplies or services furnished as needed or at the request of the resident, may be paid for by the resident from the personal incidental allowance or by outside sources, such as relatives and friends:

(a) Outside barber and beautician services if requested by the resident;

(b) Personal supplies, such as toothbrushes; toothpaste or powder, mouthwashes; dental floss; denture cleaners; shaving soap; cosmetics and shaving lotions; dusting powder; cosmetics; personal deodorants; hair combs and brushes; and menstrual hygiene supplies;

(c) Dry cleaning of personal clothing provided by outside provider;

(d) Recliner chairs, standard easy chairs, radios, television sets, etc., that the resident desires for personal use;

(e) Special wheelchairs; e.g., motorized, permanent leg support, hand controlled, if needed by resident, and recommended by the attending physician. If the resident does not have sufficient funds for this equipment, Title XVIII and XIX funds should be used;

(f) Personal clothing, including robes, pajamas and nightgowns (Bed clothing, such as hospital gowns, must be provided by the facility.);

(g) Miscellaneous items, such as tobacco products and accessories; beverages and snacks served at other than mealtime except for supplemental nourishment; television rental for individual use; stationery supplies, postage, pens and pencils; newspapers and periodicals; long-distance telephone services; non-prescription vitamins or combinations of vitamins with minerals, when ordered by the attending physician and the resident or guardian approves such use of the resident's funds.

(3) Restrictions on charges. Charges by the facility for items or services furnished Title XIX residents are not allowed as a charge against the Title XIX resident or outside sources, if separate charges are not also recorded by the facility for all non-Title XIX residents receiving these items or services directly from the facility. Charges must be for direct, identifiable services or supplies furnished individual residents:

(a) A periodic "flat" charge for routine items, such as beverages, cigarettes, etc., is not allowed. Charges may be made only after services are performed or items are delivered and charges are not to exceed charges to all classes of residents for similar services;

(b) Discretion must be exercised in making purchases for the resident. Items not pertinent to personal care and comfort should not be purchased and due care must be exercised in purchasing high cost, luxury or unusual items.

(4) Property identification. Private property shall be clearly marked with the resident's name. The facility must keep a record of private property. If items "disappear," the circumstances of disappearance must be documented in the facility's records. The facility may be responsible for losses.

(5) Records. The facility must handle each resident's account if the resident or guardian chooses not to assume this responsibility. This determination must be documented at the time of admission and at the annual IDT meeting. If the facility does handle the account, it must maintain a record of all monies belonging to the resident which have been received by or entrusted to the facility. The facility shall give an accounting of financial transactions made on behalf of the resident. Statements of account shall be provided to the resident and/or legal guardian without charge on a quarterly basis. Statements of accounts shall also be issued to the DD Case Manager and D & ES's Exit Team, as appropriate, quarterly:

(a) If PIF funds are deposited in a bank, they shall be deposited in an account separate and apart from any other bank account(s) of the facility. Any interest earned on this account shall be credited to the applicable resident's accounts;

(b) The facility shall maintain Resident Account Records for each Title XIX resident for whom the facility holds money. This record shall show in detail, with supporting verification, all monies received on behalf of the individual resident and the disposition of all funds so received. Persons shopping for residents, such as aids, volunteers, DD Case Managers, or family members, shall provide a list showing description and price of items purchased, along with receipts for these items. Outing planning sheets must be attached to the receipts, as appropriate. Records shall be available in the facility for audit and inspection by representatives of the Division. The facility shall notify the local SPD or AAA branch office and DD Case Manager when such monies exceed the asset limit established by Social Security for any individual resident so that provision can be made for application of any excess amount to the current cost of care;

(c) Availability of funds. Residents' funds on deposit with the facility shall be available to residents and/or the legal guardians upon request. It is *suggested* that a time schedule be posted in the facility stating the hours each day when the office shall be open for withdrawal or deposit of funds. Arrangements for funds should be made in writing 24 hours in advance; funds for group outings 48 hours in advance, funds for weekend use on the preceding Friday. No funds shall be withdrawn from accounts of residents capable of making their own decisions without their permission. Withdrawals must be documented in the Resident's Account Record. Any program implemented which trains residents in possession and use of money must be documented in the Individual Program Plan and be consistent with the resident's needs and goals;

(d) Disagreements. Should the facility's Interdisciplinary Team, DD Case Manager, legal guardian and/or family disagree as to whether or not the resident is capable of handling his or her own funds, the DD Case Manager shall refer the matter to the D & ES Unit's Interdisciplinary Team for a decision. If disagreement continues, the matter should be referred to CAF for Fair Hearing;

(e) Discharge of resident. On discharge, the facility gives to the resident and/or legal guardian a final accounting of personal funds and a check for any balance on deposit with the facility;

(f) Death of resident. Within 30 days following the death of a Medicaid resident, a remittance for the balance of the resident's personal incidental funds, not used for burial, along with name and case number, shall be forwarded by the facility to the designated personal representative(s) or, if none exists, to the: Estate Administration Unit, 500 Summer Street, N.E., P.O. Box 14021, Salem, OR 97310-1015. At death, personal property such as television sets, radios, wheelchairs, and other property of more than nominal value belong to the resident's estate;

(g) Sale of facility. Upon sale or other transfer of ownership interest of a facility, both transferor and transferee share joint responsibility in transferring resident's personal incidental fund monies and records in an orderly manner;

(h) Suspension of payments. Failure to properly record the receipt and disposition of personal incidental funds shall constitute grounds for suspension of provider payments to the facility.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0065
Payments

(1) Bills shall be submitted to the Division as soon as possible after the date service is rendered. The Division will not make payment for services which were provided more than 24 months prior to presentation of the claim to the Division.

(2) The local SPD or AAA branch office shall notify the facility of any known funds, and their location, available to a resident for personal incidental needs. Such funds will be offset by crediting the established Title XIX amount paid to that facility as specified in OAR 309-043-0060(1)(a), (b) and (c). The total available income shall be deducted as a credit toward the amount billed. Funds which become known to the facility shall be reported to the local SPD or AAA branch office. The facility is responsible for collecting such funds.

(3) The total available income, after personal incidental needs are met, shall be deducted as a credit toward the amount billed. Funds which become known to the facility shall be reported to the local SPD or AAA branch office. The facility is responsible for collecting such funds.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0070
Days Chargeable

(1) The Division will pay for the day of admission, but not for the day of discharge, transfer, or death.

(2) Vacancies. The Division may make payment for a vacant bed up to 30 days only in Small and Large Residential Training Facilities. Any vacancy longer than 30 days must be prior authorized by the Developmental Disability Services Medicaid Specialist. The facility must notify the Medicaid Specialist in writing at least one week prior to the expiration of the 30-day vacancy to request approval to continue the vacancy. The request must be submitted in accordance with criteria established by the Division. The Developmental Disability Services Medicaid Specialist will evaluate and approve requests on a case-by-case basis.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0075
Services Billed

(1) Billings to the Division shall in no case exceed the customary charges to private clients for any like item or service charged by the facility.

(2) In determining the customary charges to private client for use in billings or calculating interim and settlement rates, the following criteria shall be applied:

(a) The private client billing rate must be for items and services comparable to the items and services included in the all-inclusive rate for ICF/MR care; and

(b) When private client rates are based on the number of beds in the room, the Division considers the lowest room charge as the usual and customary charge for services; or

(c) When ancillary charges are made to private clients in addition to a basic charge, the Division considers the usual and customary charge to be the lowest basic room charge plus the average ancillary charge for those items included in the ICF/MR rate. The average ancillary charge is determined by dividing the ancillary revenue by the number of private client days; or

(d) When a point system is used to determine private client rates, the Division considers the usual and customary charge to be the average charge for services in subsection (a) of this section. The average charge shall be calculated by dividing private client revenue, less one-time charges (for items such as medical evaluations, dental screenings, and admission fees), by private client days; or

(e) When charges are based on the classification of the client (i.e., Medicare, Medicaid, Private), the Division considers the usual and customary charge to be the rate for private clients exclusive of ancillary charges.

(3) The facility's private client billing rates are to be entered on the ICF/MR Cost Statement.

(4) Bills shall be processed on DMAP-approved billing forms or electronic media.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0080
Reserved Bed Payments

(1) The Division may make a reserved bed payment for those residents whose Individual Program Plan provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absence due to hospitalization or convalescence in a nursing facility. In Small and Large Residential Training Facilities the DD Case Manager must be notified in writing of any resident's absence from the facility. In Full Service Residential Training Facilities, the facility's medical records office and billings unit must be notified in writing of any resident's absence from the facility.

(2) Prior to the resident's departure for leave to exceed 14 consecutive days, the Small or Large Residential Training Facility must submit a written request to the DD Case Manager for authorization of reserved bed payments. The medical records office in Full Service Residential Training Facilities must submit a written request to the Developmental Disability Services Medicaid Specialist for authorization of reserve bed payments. In case of emergency, notification should be made as soon as possible; but in any event not later than the working day following the resident's departure:

(a) Absences of 14 days or less do not require prior authorization, but the Division reserves the right to decline payment, if appropriate;

(b) For Small and Large Residential Training Facilities the DD Case Manager must notify the Developmental Disability Services Medicaid Specialist, of any temporary absence in excess of 30 consecutive days. For Full Service Training Facilities, the medical records office must notify the Developmental Disability Services Medicaid Specialist of any temporary absence in excess of 30 consecutive days. Prior authorization of such absences requires the signature of both the DD Case Manager and the Medicaid Specialist for residents in Small and Large Residential Training Facilities. For Full Service Residential Training Facilities, prior authorization of such absence requires the signature of the Developmental Disability Services Medicaid Specialist.

(3) The DD Case Manager shall notify the local SPD or AAA branch office in writing of any reserved bed denials for residents in Small and Large Residential Training Facilities. The Developmental Disability Services Medicaid Specialist shall notify the local SPD or AAA branch office in writing of any reserve bed denials for residents in Full Service Residential Training Facilities. Reserved bed payments will not be made for a resident who does not return to the facility on or before expiration of any temporary or prior authorized absence unless the facility terminated the leave of absence and discharged the resident immediately upon learning the resident would not return to the facility.

(4) Reserved bed payments shall be limited to 14 days in any 30-day period, except for those absences prior authorized by the DD Case

Manager or the Developmental Disability Services Medicaid Specialist.

(5) Failure of the facility to comply with the provisions of this rule shall relieve the Division and the Title XIX resident of all responsibility to make payment to the facility during the resident's absence. The provisions of this section are separate and apart from OAR 309-043-0065.

(6) Residents temporarily absent overnight or longer from the facility on activities under the supervision of and/or at the expense of the facility shall be considered as remaining in the facility. This includes special trips of an educational or training nature, and recreational activities such as camping, fishing, hiking, etc.

(7) If respite care is provided in a reserved bed, Title XIX billing shall be reduced by the amount of money received for this service. The DMAP-approved billing form must indicate the name of the person receiving respite care and show a credit for the amount of money received for that care.

Stat. Auth.: ORS 179 & 430
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0085
Transfer or Discharge of Residents

(1) Transfer of residents:

(a) A resident shall not be transferred to another facility without review and discharge planning by the Interdisciplinary Professional Team of the transferring facility. The DD Case Manager must participate in the discharge planning and the plan must be submitted to the MHDDSD D & ES Unit in Salem for final approval. The discharge plan shall be submitted by the DD Case Manager;

(b) The DD Case Manager shall discuss any planned move from one facility to another with the resident, guardian, and relatives of the resident, as appropriate;

(c) In FSRTF's, the Unit Social Worker shall refer residents for discharge directly to D & ES for discharge planning;

(d) Failure on the part of the facility administration to comply with this rule shall constitute a basis for withholding payment.

(2) Discharge of residents:

(a) Requests for discharge of residents may be initiated to the DD Case Manager by the facility's Interdisciplinary Team, the resident, the resident's family, and/or the resident's legal guardian;

(b) The DD Case Manager will coordinate the plans for discharge. A discharge plan must include provision for appropriate services in the resident's new environment, protective supervision, if required, other follow-up services, and appropriate written documentation from the client's record. The DD Case Manager will discuss the discharge plans with the resident and/or legal guardian;

(c) When a resident is permanently discharged, the facility must prepare and place in the resident's record a summary of findings, progress and plans;

(d) The Mental Health and Developmental Disability Services Division's D & ES Unit in Salem shall have final approval for all discharge plans;

(e) Failure on the part of the facility administration to comply with this rule shall constitute a basis for withholding payment.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0090
Accounting and Record Keeping

(1) ICF/MR Cost Statements shall be prepared in conformance with generally accepted accounting principles and the provisions of this rule. Where a conflict exists, the provisions of these rules shall prevail.

(2) Full Service Residential Training Facilities shall apply Medicare Principles of Reimbursement when filing ICF/MR Cost Statements. All other facilities shall file ICF/MR Cost Statements using the accrual method of accounting.

(3) The facility shall maintain, for a period of not less than three years following the date of submission of the ICF/MR Cost Statement to the Division, financial and statistical records of the period covered by such cost statement which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved audit questions at the end of this three-year period, the records must be maintained until the questions are resolved. The records shall be maintained in a condition that enable them to be audited for compliance with generally accepted accounting principles and provisions of these rules.

(4) Expenses reported as allowable costs must be adequately documented in the financial records of the facility or they shall be disallowed.

(5) The Division shall maintain each required ICF/MR Cost Statement submitted by a provider for three years following the date of submission of the report. In the event there are unresolved audit questions at the end of this three-year period, the cost statement shall be maintained until such questions are resolved.

(6) The records of the facility shall be available for review without notice by authorized personnel of the Department and of the U.S. Department of Health and Human Services during normal business hours at a location in the State of Oregon specified by the facility.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0095
Professional Services

(1) No professional consultation, treatment, evaluation or medical service costs other than the following will be included in the facility's all-inclusive rate: Dentist*; dietitian; interpreter for the deaf; occupational therapist; pharmacist*; physical therapist; psychologist; qualified mental retardation professional; registered nurse; social worker; speech pathologist/therapist; audiologist; and recreation therapist.

NOTE: *Means for consultation services beyond costs paid under the appropriate DMAP provider guide.

(2) Full Service Residential Training Facilities shall provide all of the professional services cited in section (1) of this rule with their own staff or by contract and their costs are included in the all-inclusive rate.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 10-1985, f. & ef. 6-13-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0100
Non-Paid Workers

(1) The Division shall consider the value of services performed by non-paid workers in positions that are normally occupied by paid personnel of the facility to be an allowable cost when all of the following criteria are met:

(a) Services are related directly to resident care or for administrative purposes essential to providing that care; and

(b) Non-paid workers spend a minimum of 20 hours per week on the job; and

(c) The non-paid workers do not receive any direct remuneration (salaries, wages or gifts) from either the facility or from the organization of non-paid workers; and

(d) The Division does not reimburse any workers for services traditionally rendered on a purely volunteer basis without expectation of any form of remuneration by the non-paid workers' organization (American National Red Cross, hospital guilds, auxiliaries, and similar organizations); and

(e) Non-paid workers are members of an organization of non-paid workers that has arrangements with the facility for the performance of services by non-paid workers; and

(f) The non-paid worker organization has a tax exempt status from the United States Internal Revenue Service; and

(g) A legally enforceable agreement exists between the facility and the organization of non-paid workers. The agreement establishes the facility's obligation to make payments to the organization for services rendered by its members; and

(h) The facility maintains records which show the value of non-paid services as rates of pay in a manner equivalent to that used for paid employees. In addition, the records contain a copy of the contract between the organization of non-paid workers and the facility; and

(i) The qualifications of non-paid workers are comparable to the qualifications of paid employees performing identical services under similar circumstances; and

(j) The calculation of the value of services of non-paid workers only includes payments to the non-paid workers' organization for that worker's services, the cost of any room and board, perquisites (such as uniforms and laundry), and fringe benefits provided free of charge by the facility. The total value of services may not exceed amounts allowed for paid employees performing similar services; nor may it exceed the amount provided by the terms of the contract between the facility and the organization of non-paid workers.

(2) The agreement between the facility and the organization of non-paid workers must include the following:

(a) Amount applicable to the value of services rendered by non-paid workers;

(b) Types of services;

(c) Title of each full-time position;

(d) Number of hours;

(e) Rates of pay per working classification (including salary, fringe benefits, perquisites, and maintenance); and

(f) Period of time during which services are rendered.

(3) Payments for services described in section (1) of this rule shall not be allowed if not paid by the facility, or if paid by the facility later than 75 days after the end of the facility's cost reporting period in which the services were rendered.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0105
Owner Compensation

(1) Compensation of owners for services normally result through the ICF/MR facility earned profit. The only other owner compensation recognized as an allowable cost is when the owner is employed in the ICF/MR and meets the provision of this rule.

(2) Reasonable compensation for services performed by owners or immediate relatives is an allowable cost, provided the services are actually performed in the ICF/MR, documented and are necessary. Persons considered to be immediate relatives are husband, wife, natural parent, child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, mother-in-law, half-brother, half-sister, father-in-law, grandparent, grandchild, uncle, aunt, nephew, niece and cousin:

(a) Reasonableness requires that the compensation allowance:

(A) Does not exceed an amount ordinarily paid for comparable services performed by either other facility employees or non-owners at other facilities; and

(B) Includes only the benefits and remuneration, regardless of the form, provided to all employees in like manner; and

(C) Is consistent with "reasonableness" as defined in OAR 309-043-0005.

(b) Services actually performed and necessary requires that:

(A) The services be only those rendered in connection with client care whether direct or indirect. This excludes services characterized as protecting the owner's investment; and

(B) The services are limited to those positions described in the salaried accounts included in the schedule of labor costs; and

(C) Had the owner not rendered the services the facility would have had to employ another person to perform them; and

(D) The services must be pertinent to the operation and sound conduct of the facility as well as comparable to services purchased by the other ICFs/ MR in similar situations.

(c) Documentation requires that:

(A) A position description exists to support the duties and responsibilities being compensated; and

(B) Employee records be maintained to support owner's work week and rate of pay, whether hourly or salary; and

(C) Compensation be paid. Accrued compensation of an owner, if not paid within 75 days after the end of the ICF/MR cost statement reporting period, shall not be included as an allowable expense except as identified in section (4) of this rule.

(3) An owner will not be compensated for services in excess of 40 hours in one week. Particular scrutiny shall be required where an owner may provide services in more than one area for more than one facility or is engaged in other occupations or business activities. Allowable compensation will be adjusted to reflect an appropriate allocation of time spent in each area.

(4) Where an owner functions as an administrator or assistant administrator, the sections of rules governing compensation of these positions apply.

(5) The allowance of compensation for services of sole proprietors and partners is the amount determined to be the reasonable value of the services rendered regardless of whether there is any actual distribution of the profits of the business. However, imputed compensation is allowable only when there is a corresponding entry to account 1970-Drawing Account-Proprietor or Partner.

(6) The fact that an owner may have potential supervisory and managerial authority and responsibility for an institution is not as important as the manner in which this authority and responsibility is actually exercised. For example, another individual, perhaps with the designation of assistant administrator, might perform most day-to-day managerial and supervisory functions in an institution. In such case, the right of the owner-administrator to overrule decisions does not constitute a basis for recognition of compensation comparable to administrators in other similar institutions. The owner is compensated for managing and protecting his or her investment through the ICF/MR profit; in this example the administrator's salary would not be an allowable cost.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0110
Auditing

(1) The Division shall audit each ICF/MR Cost Statement within six months after it has been properly completed and filed with the Division. The audit will be performed by either desk review or field visit.

(2) The desk review shall verify, to the extent possible:

(a) That the facility has properly included its allowable costs on the ICF/MR Cost Statement on the basis of generally accepted accounting principles and in compliance with these rules; and

(b) That the facility has properly applied the cost finding method to its allowable costs as specified by the Division in accordance with OAR 309-043-0040;

(c) Whether further auditing of the facility's financial and statistical records is needed.

(3) All ICF/MR Cost Statements filed with the Division shall be subject to a field audit, normally to be completed within one year from the date of filing.

(4) The field audit shall, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to; and

(b) Reported data is in agreement with supporting records; and

(c) The ICF/MR Cost Statement is reconcilable to the appropriate IRS report and payroll tax reports;

(d) The model budget rate described in OAR 309-043-0005 supports 100 percent of an efficiently and economically operated facility.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0115
Capital Assets

Capital Assets included on the ICF/MR Cost Statement are as follows:

(1) Tangible assets of the following types in which a provider has an economic interest are subject to depreciation:

(a) "Buildings" mean the basic structure or shell and additions thereto;

(b) "Building fixed equipment" means attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, and air conditioning system. The general characteristics of this equipment are:

(A) Affixed to the building and not subject to transfer;

(B) A fairly long life, but shorter than the life of the building to which affixed.

(c) "Moveable equipment" means such items as beds, wheelchairs, desks, vehicles, and other depreciable items;

(d) "Land improvements" means such items as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., the replacement of which is the responsibility of the facility;

(e) "Leasehold improvements" means the betterments and additions made by the lessee to the leased property which become the property of the lessor after the expiration of the lease.

(2) Land is not depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, and the cost of curbs and sidewalks, replacement of which is not the responsibility of the facility.

(3) Amortization of intangible assets shall not be included in calculating the reimbursement rate except for those specifically mentioned in the following rules:

(a) Start-up costs as provided in OAR 309-043-0135; and

(b) Organization costs as provided in OAR 309-043-0140.

(4) Assets shall be capitalized and depreciated if they have historical costs in excess of the level required by the lower of:

(a) The State of Oregon accounting policy; or

(b) The Medicare capitalization policy.

(5) Repair costs in excess of $1,000 on equipment or buildings must be capitalized to the extent that they extend the useful life beyond the originally estimated useful life, expand the capabilities, or result in a betterment of the asset.

(6) Certificate of Need shall be capitalized and amortized as part of the building cost.

(7) The facility shall maintain receipts and depreciation schedules of capital assets to document amounts reported on the ICF/MR Cost Statement.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0120
Depreciation

(1) Basis:

(a) Purchase of new facility. The basis for depreciation of a new facility shall be the historical cost of building the facility, including preparation for use, or the purchase price from an unrelated organization not to exceed the fair market value, including preparation for use, less salvage value;

(b) Purchase of ongoing facility. The basis for depreciation of an ongoing facility acquired from an unrelated organization is limited to the lower of the following:

(A) The allowable acquisition cost of such asset to the first owner of record on or after July 18, 1984;

(B) The acquisition cost of such asset to the new owner; or

(C) The fair market value of the asset on the date of acquisition.

(c) To properly provide for cost or valuation of fixed assets, appraisal by an expert will be required if the facility has no historical cost records, has incomplete records of depreciable fixed assets, or purchases a facility without designation of purchase price for the class of assets acquired. The appraisal shall be subject to the approval by the Division. In any case, the Division may require such appraisal to establish the fair market value of the facility's assets;

(d) If the purchase is from a related organization, the cost basis is the lower of the cost basis of the related organization, or the cost basis as determined by subsections (1)(b) and (c) of this rule, less depreciation as determined by the provisions of this rule;

(e) The basis for depreciation of assets other than as described in subsections (1)(a) and (b) of this rule shall be the historical cost to the facility from an unrelated organization plus set-up costs, less salvage value. The basis shall not exceed the fair market value. In the case of a trade-in, the historical cost will consist of the sum of the book value of the trade-in plus the cash paid. In cases where the asset is purchased from a related organization, the basis shall not exceed the asset's book value as determined under the provisions of this rule;

(f) Depreciation expenses associated with donated assets shall be included in the calculation of the reimbursement rate as provided in OAR 309-043-0145;

(g) The asset value and annual depreciation shall be reduced by the value of assets determined to be both not necessary and not related to resident care;

(h) Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation;

(i) Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets. Funded depreciation account funds must be placed in readily marketable investments of the type that assures the availability and conservation of the funds. Additions to the funded depreciation account must remain in the account for at least six months to be considered valid funding transactions.

(2) Methods. The straight-line method of depreciation shall be the only method used in depreciating assets, effective on and after November 1, 1978:

(a) If other depreciation methods used were in use prior to November 1, 1978, the cost basis on that date shall be the undepreciated balance. The method and procedure for computing depreciation must otherwise be applied on a basis consistent from year to year;

(b) The additional first year allowance is not allowable.

(3) Asset lives:

(a) Small and Large Residential Training Facilities shall use Internal Revenue Service guidelines for setting asset lives when computing allowable depreciation for Title XIX reimbursement purposes for assets acquired before January 1981. The lives of assets not covered by Internal Revenue Service guidelines which cost more than $200 individually and $400 aggregate are subject to approval by the Division. For assets acquired on or after January 1, 1981, facilities shall use the useful life guidelines published by HCFA or other guidelines as established at **42 CFR 413.134(b)(7)(i)**.

(b) For Small and Large Training Facilities improvements to leased property which are the responsibility of the facility under the terms of the lease shall be depreciated over the useful life of the improvement or over the remaining length of the lease, whichever is shorter. The improvement shall be depreciated only over the useful life of the improvement in the case of lease to a related party;

(c) Full Service Residential Training Facilities shall use Medicare principles to determine asset lives for depreciation.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 7-1985(Temp), f. & ef. 5-14-85; MHD 15-1985, f. & ef. 9-25-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0125
Retirement or Disposal of Depreciable Assets

(1) Retirement of assets:

(a) Depreciation shall no longer be taken on depreciable assets which are disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. No further depreciation shall be taken on permanently abandoned assets;

(b) When an asset has been retired from active use but is being held for standby or emergency service, and there is a likelihood that it can be effectively used in the future, depreciation may be taken.

(2) Gains on disposal of depreciable assets:

(a) A gain on the sale or trade of an asset is the excess of all proceeds received for the asset over its remaining undepreciated base. Any gain on the sale or trade of a depreciable asset, either during the period of participation in the program or within 12 months following termination, shall be included in computing the settlement rate for the period in which the asset was disposed as follows:

(A) For assets with expected useful lives of less than 100 months, that portion of the total gain relative to the reimbursement for Title XIX residents shall be subject to recovery as set forth in paragraphs (2)(a)(C) and (D) of this rule shall; and

(B) For assets with expected useful lives of 100 months or more, that portion of the total gain relative to the reimbursement for Title XIX residents, subject to recovery as explained in paragraphs (2)(a)(C) and (D) of this rule shall be limited to the total gain reduced by one percent for each month of ownership; and

(C) Any gain on the sale or trade of an asset will be spread over the actual life of the asset on the same basis as depreciation was allowed to the date of retirement. Depreciation schedules for fiscal years during which the facility participated in the ICF/MR program shall be adjusted by reducing the depreciation expense taken for that asset. The difference between reimbursement actually paid for depreciation in any period beginning November 1, 1978, and the reimbursement for depreciation which would have been paid with the depreciation schedules adjusted to reflect the gain shall be recovered by the Division as explained in paragraph (2)(a)(D) of this rule; and

(D) In the period an asset is sold or traded, any gain shall be recovered by reducing the settlement rate by the amount of the gain as calculated in paragraph (2)(a)(C) of this rule, divided by the total Title XIX resident days; and

(E) A loss on the sale or trade of an asset is the excess of the remaining undepreciated base over all proceeds received for that asset. A loss shall not be included in the calculation of the reimbursement rate; and

(F) All proceeds from the sale of donated assets shall be treated as a donation as provided in OAR 309-043-0145.

(b) Losses from the disposal of depreciable assets are not allowable cost for ICF/MR reimbursement except in facilities following Medicare principles of reimbursement. In these facilities, Medicare principles regarding disposable assets will apply.

(3) Payments to providers shall not be increased, solely as a result of a change of ownership, in excess of the increase which would result from applying Section 1861(v)(1)(O) of the Social Security Act as applied to owners of record on or after July 18, 1984.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 11-1984(Temp), f. & ef. 12-21-84; MHD 10-1985, f. & ef. 6-13-85; MHD 14-1985(Temp), f. & ef. 8-13-85; MHD 17-1985, f. & ef. 10-25-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0130
Equity

(1) An allowance of ten percent return on average equity capital invested and used in the provision of resident care is included as an allowable cost in determining reimbursement, subject to the maximum payment level. This allowance shall be payable only to profit making proprietary entities and shall not be allowable to non-profit or governmental entities.

(2) The average equity capital of the provider will be determined by adding together the beginning and ending equity capital for the reporting period and dividing by two. The product of the average equity capital and the rate of return on equity shall be included on the ICF/MR Cost Statement in calculating the cost per resident day. If the net average owner's equity is zero or negative, there will be no return:

(a) Generally accepted accounting principles are to be used for computing owner's equity unless otherwise specified in this rule;

(b) Assets and liabilities not related to providing resident care and home office assets and liabilities are not includable in the facility's equity capital;

(c) Loans from owners or related entities are considered invested equity capital of the facility for which the allowance of a return on equity capital in section (1) of this rule will apply;

(d) Owner's equity in assets leased from related entities is includable in the equity capital of a proprietary facility;

(e) Goodwill is not includable as part of owner's equity;

(f) Amounts deposited in a funded depreciation account and the earnings on these deposits are not included in equity capital;

(g) Land, buildings, and other assets acquired in anticipation of expansion are not includable in equity capital. Construction-in-process and liabilities related to such construction are not includable in equity capital;

(h) Prepaid premiums on life insurance carried by a facility on officers and key employees, which designate the facility as the beneficiary, are not includable in equity capital;

(i) The costs of noncompetitive agreements are not includable in equity capital;

(j) The amount deposited in, and the earnings of, a self-insurance reserve fund are not includable in equity capital;

(k) The unrecovered loss of an asset which is totally or partially destroyed by a casualty is not includable in equity capital;

(l) Working capital, defined as the difference between current assets and current liabilities, shall be adjusted by any amount determined to be excessive for the necessary and proper operation of resident care activities. The excessive amount will not be included in equity capital;

(m) The cash surrender value of insurance is not includable in equity capital;

(n) Imputed salaries for proprietors will be offset in computing the equity capital;

(o) Donations shall not be included as part of owner's equity;

(p) Any portion of an acquisition cost incurred on or after July 18, 1984, that exceeds the depreciable basis, as defined by OAR 309-043-0120, is not includable in the owner's equity calculation.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 7-1985(Temp), f. & ef. 5-14-85; MHD 15-1985, f. & ef. 9-25-85

309-043-0135
Start-up Costs

(1) Necessary and ordinary start-up costs will be allowable if they are amortized over not less than 60 consecutive months beginning with the month in which the first ICF/MR resident is admitted for care.

(2) Start-up costs will be limited to those appropriate costs incurred within six months prior to the date of admission of the first ICF/MR resident to the facility.

(3) The Division may grant an extension to the six-month limitation if the opening of the facility is delayed by the Department of Human Services or one of its Divisions.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0140
Organizational Costs

(1) Necessary and ordinary costs which are directly incident to the creation of a corporation or other form of business of the facility, shall be allowable if they are amortized over not less than 60 consecutive months beginning with the month in which the first ICF/MR resident is admitted for care.

(2) Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation. Cost relating to the issuance and sale of shares of capital stock or other securities are not allowable.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0145
Offset Income and Donations

(1) Except as prescribed in subsection (1)(b) and section (2) of this rule all income may be used to offset expenses:

(a) If a facility provides a service which results in a revenue producing activity which is non-allowable cost (i.e., activity center, TMR Class, sheltered workshop, skilled nursing), the revenue shall be offset as follows:

(A) If the revenue is less than two percent of the total facility expense (sum of cost areas), it shall be offset against the appropriate expense;

(B) If the revenue is two percent or more of the total facility expenses (sum of cost areas), costs must be allocated to this area as described in OAR 309-043-0040.

(b) Income for routine services or supplies included in the all-inclusive rate will not be offset against expenses.

(2) Donations made to an ICF/MR will be included in the calculation of the reimbursement rate as follows:

(a) Grants, gifts, or endowment income designated by a donor for paying a specific operating cost will be offset against that cost;

(b) Unrestricted grants, gifts, and income from endowments will not be offset from operating costs in computing reimbursable costs;

(c) The basis of depreciation for a donated asset:

(A) If acquired from a related organization, shall be the lesser of:

(i) Fair market value at the date of acquisition; or

(ii) The basis the related party had or would have had if they participated in the program.

(B) If acquired from a non-related organization, shall be the fair market value at the date of acquisition.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0150
Related Party Transactions, Chain Operations, Home Office Cost

(1) Related party transactions:

(a) Except as provided in subsection (1)(b) of this rule, costs applicable to services, facilities and supplies furnished to a facility by organizations related to the facility by common ownership or control are allowable at the lower of cost excluding profits and mark-ups to the related party or charge to the facility:

(A) Compensation paid to employees is also reviewable under the test of reasonable compensation for services performed by owners as described in OAR 309-043-0105;

(B) Related party costs are allowable to the extent that they relate to resident care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer;

(C) Related party costs that are not otherwise allowable costs when incurred directly by the facility shall not be allowable as related party costs;

(D) Documentation of costs to related parties shall be made available at time of audit. If documentation is not available, such payments to or for the benefit of the related organization will be disallowed.

(b) An exception to the general rule on related organizations may be granted if the facility demonstrates by clear and convincing evidence to the satisfaction of the Division:

(A) That the supplying organization is a bona fide separate organization; and

(B) That a substantial part of the supplying organization's business activity, of the type carried on with the facility, is transacted with other organizations not related to the facility and the supplier by common ownership or control, and that there is an open, competitive market.

(c) Rental expense paid to related organizations for facilities or equipment shall be allowable to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on mortgage) or leasing the assets, computed in accordance with the provisions of this rule.

(2) Chain operations:

(a) A chain operation consists of a group of two or more health care facilities including one or more ICFs/MR which are owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains but also chains operated by various non-profit entities including counties, hospital districts, and religious and other charitable organizations;

(b) Home offices of chain operations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a chain is normally not a facility itself, it may furnish to the individual facility central administration and/or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services to the facility is includable in the facility's allowable costs under the program;

(c) Home office costs that are not otherwise allowable costs when incurred directly by the facility shall not be allowable as home office costs to be allocated to facilities. Where the home office is a holding company and provides no services related to resident care, neither costs nor equity capital of the home office may be recognized as allowable cost to the facilities in the chain;

(d) If an owner receives compensation from the home office for services to the facility, that compensation shall be allowable only to the extent that it is related to resident care and to the extent that it is reasonable as defined in OAR 309-043-0105.

(3) Allocation of home office cost:

(a) Home office costs attributable to a specific facility shall be reported in the Home Office expense column of the ICF/MR Cost Statement except for facilities following Medicare principles of reimbursement. In these facilities, home office costs will be reported on the Medicare Home Office Cost Report. The costs reported are to be the net allowable costs defined in section (2) of this rule and based on the account definitions in OAR 309-043-0200;

(b) The home office will attach a worksheet to the cost statement for the facility showing the detailed gross home office costs, adjustments, and net home office allowable costs and the allocated costs to each facility and non-resident (client) related activity;

(c) The home office will include, on the attached worksheet, the allocation method(s) used to allocate costs to the facility or facilities. Generally, costs will be based on beds, resident days or other bases, whichever most equitably allocates such costs. Revenue is not generally appropriate for distributing these costs;

(d) Home office costs directly attributable to a specific facility, such as administrator's salary, shall be reported as part of the facility's costs in the facility's gross expense column of the cost statement.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90

309-043-0155
Management Fees

Management fees are an allowable expense if they are necessary, reasonable, non-duplicative of facility personnel and functions, and are documented by a binding contract with a non-related party defining the items, services and activities provided. If the administrator or assistant administrator is supplied as part of the contract, the rule governing their compensation applies and adjustments may be made. Documentation demonstrating that the services were actually performed shall be required. Management fees paid to a related organization are subject to OAR 309-043-0150.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0160
Administrator

(1) Each facility shall employ an Administrator who meets federal ICF/MR requirements. This person must act for the facility's governing body in the overall management of the ICF/MR and arrange for an employee to be responsible for the administration of the ICF/MR at all times.

(2) No assistant Administrator salary shall be allowed in facilities with less than 59 beds. One full-time Assistant Administrator salary shall be allowed in facilities with 59 beds or over. There are no licensing or educational requirements for the Assistant Administrator.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0165
Legal and Accounting Costs

Legal and accounting costs, which include legal and administrative actions to resolve a disagreement with the state regarding resident care shall be an allowable cost in the base cost category.

Stat. Auth.: ORS 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81

309-043-0170
Non-Allowable Costs

Non-allowable costs include, but are not limited to:

(1) Bad debt expense, except as related to Title XIX recipients;

(2) Cost of basic research (including Section 1122 of Social Security applications if rejected);

(3) Concession and vending machine costs;

(4) Amortization of noncompetitive agreement;

(5) Funeral and cemetery expenses (except in FSRTF);

(6) Goodwill;

(7) Laboratory salaries and supplies (except in FSRTF);

(8) Pharmacy salaries (except in FSRTF);

(9) Physician salaries (except in FSRTF);

(10) Religious salaries, supplies and space;

(11) X-ray salaries and supplies (except in FSRTF);

(12) Personal purchases;

(13) Federal and other governmental income taxes;

(14) Penalties and fines and related interest and bank charges other than regular service charges;

(15) Miscellaneous expenses not related to resident care;

(16) Donations and contributions;

(17) Expenses for barber and beautician services not included in routine care;

(18) Costs of services and items otherwise reimbursable through CAF Medical Programs (except in FSRTF);

(19) Costs of services and items otherwise reimbursable through the resident's personal funds;

(20) Compensation of officers, directors, stockholders, and others associated with a provider not related to residential care;

(21) Interest on loans to or from owners;

(22) Costs which have not been incurred but have been recorded in conjunction with balance sheet reserve accounts (appropriations of retained earnings), such as self-insurance cost accounts and reserve accounts. The actual allowable costs associated with these accounts shall be recognized only in the period incurred;

(23) Key man insurance;

(24) Assistant administrator salaries in facilities with less than 59 beds;

(25) Advertising, except help wanted advertising;

(26) Cash shortages;

(27) Undocumented amounts;

(28) Salaries not paid within 90 days after the end of the ICF/MR cost report period;

(29) Vehicle and aircraft costs not related to facility business, to resident care and/or resident recreation;

(30) Out-of-state travel expense except for Full Service Residential Training Facilities; in-state industry sponsored workshop or conference expenses are limited to the administrator or assistant administrator plus the director of nursing services and other staff employed in the facility;

(31) Leasehold purchase expenses;

(32) Employee benefits and allowances not provided to all full-time employees or their substantial equivalent;

(33) Costs (including legal fees, accounting and administrative costs, travel costs, and costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made; and

(34) On or after July 18, 1984, interest expense related to that portion of the acquisition price of an ICF/MR that exceeds the depreciable basis (OAR 309-043-0120) will not be reimbursable.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 7-1985(Temp), f. & ef. 5-14-85; MHD 15-1985, f. & ef. 9-25-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0175
Filing of Cost Statement

(1) The ICF/MR Cost Statement and the Medicare Cost Form 2552 plus the MHDDSD calculation of reasonable cost form are uniform cost reports containing actual financial data from operation of ICF/MR facilities. Full Service Residential Training Facilities shall fill out the Medicare Cost Form and Calculation of Reasonable Cost. All other facilities shall report financial data on the ICF/MR Cost Statement in accordance with instructions provided by the Division. FSRTFs will follow the guidelines provided with the Medicare Form 2552:

(a) Gross costs and revenues on the cost reports shall agree with the statement of earnings and expenses or profit and loss statement of the facility;

(b) Home office financial data on the cost reports shall be reconcilable to the home office financial statements and records;

(c) The ICF/MR Cost Statement shall be reconcilable to the appropriate IRS report and payroll tax reports.

(2) Facilities shall file proper cost statement(s) as prescribed in section (1) of this rule annually with the Division's Audit Unit reporting actual financial data experienced in the latest fiscal period of operation of the facility. These reports will be filed for less than an annual period only when necessitated by the facility terminating its agreement with the Division, change in ownership, change in program reimbursement methodology, change in fiscal period, or for special time periods as may be reasonably established by the Division. The facility should use the same fiscal period for the cost statement(s) as used for the applicable federal tax return, the two of which must be reconcilable. Cost statements are due within 90 days after the end of the normal fiscal period, change in program reimbursement methodology, change of ownership, or withdrawal from the program or special time periods as requested by the Division.

(3) A report containing false information provided by the facility, knowingly or with reason to know, shall constitute cause for termination of the facility's agreement with the Division. Facilities filing false reports may be referred for prosecution under applicable statutes.

(4) Each required cost statement shall be signed by the individual who normally signs the facility's federal income tax return. If the cost statement is prepared by someone other than an employee of the facility, the individual preparing the cost statement is also required to sign and indicate his or her relationship to the provider.

(5) ICFs/MR that are a distinct part of a facility certified to provide intermediate or skilled nursing care shall complete and submit a Nursing Home Cost Statement with the ICF/MR Cost Statement. A schedule showing the allocation between ICF/MR services and intermediate or skilled nursing care services shall be submitted with the cost statement.

(6) Improperly completed or incomplete cost statements will be returned to the facility for proper completion and shall be returned to the Division within 30 days.

(7) If the cost statement is not submitted within the required time period, the interim rate then in effect shall be reduced to the settlement rate established from the last audited or desk reviewed cost statement. If a settlement rate has not been establish, then the interim rate will be reduced to the interim rate in effect prior to the last increase granted in the interim rate. The reduced interim rate shall remain in effect until the first of the month following submission of a properly completed cost statement.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0180
Rate Setting

(1) Except as described in section (2) of this rule, the Division shall use a per diem reimbursement rate schedule to establish maximum allowable ICF/MR reimbursement rates determined by the State of Oregon to represent 100 percent of the reasonable cost of an economically and efficiently operated facility. Separate rates shall be established for each class of ICF/MR facility. The rate for a facility within each class will be based on the rate schedule and may vary depending on the number and ICF/MR class of residents in the facility. The maximum reimbursement rate for each facility shall be established by the Division by dividing 95 percent of the facility's licensed ICF/MR bed capacity into its total per diem reimbursement rate.

(2) Full Service Residential Training Facilities shall be reimbursed using an interim rate as provided in OAR 309-043-0185(2) and settlements will be determined as described in OAR 309-043-0195(2).

(3) The Division's rate schedule will consist of two major cost categories: base cost and labor cost. OAR 309-043-0200 describes cost centers within these cost categories:

(a) Base costs for each class of ICF/MR shall be based on amounts determined by the State of Oregon to be reasonable in similar residential facilities; i.e., residential training facilities or nursing facilities which are not certified to provide ICF/MR services;

(b) Labor costs for each class of ICF/MR shall be based on requirements in the federal regulations, state licensing requirements, the state's experience in state-operated ICFs/MR, and costs determined by the State of Oregon to be reasonable in similar facilities; i.e., group care homes or nursing facilities, which are not certified to provide ICF/MR services.

(4) Except as described in section (2) of this rule, the Division's rate schedule shall be reviewed annually by reviewing each facility's cost as submitted on the ICF/MR Cost Statement and comparing actual allowable costs to the per diem reimbursement rate schedule. Based on this review, the per diem reimbursement rate schedule may be revised to assure reasonable and adequate rates consistent with efficiency, economy, and quality of care. Copies of the rate schedule for each fiscal year will be available at the Division.

(5) Settlement rates shall be established for each facility on a retrospective basis for each facility's fiscal year as provided in OAR 309-043-0195.

(6) An interim rate schedule may be established by the Division if in its judgment economic trends, interim ICF/MR Cost Statements, CPI, or other evidence indicates that the rate schedule no longer constitutes reasonable cost reimbursement:

(a) The Division may require ICF/MR facilities to submit ICF/MR Cost Statements between facilities' regularly scheduled ICF/MR Cost Statements;

(b) The Division shall give facilities 90 days notice to submit interim ICF/MR Cost Statements;

(c) Failure to submit interim ICF/MR Cost Statements shall subject the facility to penalties set forth in OAR 309-043-0175.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 3-1982(Temp), f. & ef. 3-3-82; MHD 8-1982, f. & ef. 5-3-82; MHD 10-1985, f. & ef. 6-13-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0185
Interim Rates

(1) For each SRTF and LRTF, the Division develops an interim rate which is the lesser of the facility's model budget rate (a) or the facility's projected net per diem cost (b):

(a) The model budget represents 100 percent of reasonable per diem costs of efficiently and economically operated facilities of that size:

(A) The model budget consists of two major cost categories: Base costs and labor costs:

(i) Base Costs (e.g., rent, utilities, administration, general overhead) are based on amounts determined by the state to be reasonable in similar sizes and types of residential facilities. The model budget rate consists of a standard per diem rate per resident for each class of facility;

(ii) Labor Costs (e.g., for direct care, active treatment, and support staff) are broken into various components. The model budget cost for each component is developed based on requirements in federal regulations, state regulations, the state's experience in state-operated ICFs/MR, and costs determined to be reasonable in similar facilities. Each component within the labor category has a model budget rate developed.

(B) The facility's model budget rate is adjusted by the most recently available resident occupancy information, but not lower than 95 percent of the facility's licensed bed capacity:

(i) The model budget rate at 100 percent occupancy is multiplied by the number of resident days at 100 percent occupancy to yield the ceiling amount in dollars;

(ii) The ceiling amount is divided by the greater of:

(I) The number of resident days projected for the facility for the upcoming fiscal period; or

(II) 95 percent of the total possible resident days available for a facility of that licensed capacity for the fiscal period.

(C) Model budgets for SRTFs and LRTFs are reviewed annually and adjustments are made based on inflation, economic trends or other evidence supporting rate changes, such as directives from the legislature or changes in program design;

(D) Model budgets will be rebased as a result of desk or field audits of the provider's cost statement.

(b) The projected net per diem cost is usually derived from the facility's latest ICF/MR Cost Statement, revised to include any adjustments applied to the per diem reimbursement rate schedule for subsequent periods. Adjustments have historically fallen into four categories:

(A) Correction to depreciation;

(B) Modifications of indirect cost allocations;

(C) Unallowable costs; or

(D) Offsets of expenses against income and donations as described in the administrative rules;

(E) However, if requested by the facility and agreed to by the Division, the facility may substitute actual allowable costs gathered from at least three months of data more recent than the latest ICF/MR Cost Statement, revised to include any adjustments applied to the per diem reimbursement rate schedule for subsequent periods. The Division will consider recent data which is the equivalent of an interim cost report by the facility. The Division will compare actual allowable costs derived from the recent data with the model budget rate and will assign a new interim rate based upon the lesser of the two.

(c) The facility or the Division may request a per diem rate adjustment if a significant change in allowable costs can be substantiated;

(d) The Division pays an interim rate to each SRTF and LRTF through the end of each fiscal year. The actual (final) payment, called the year-end settlement, is discussed in OAR 309-043-0195. In the year-end settlement, the Division takes into account the interim rate payments already made and compares those payments with the settlement rate.

(2) For each FSRTF, the interim rate shall be based on the facility's projected costs. Each facility shall submit their projected costs, and rationale for the projections, to the responsible Title XIX intermediary. The Title XIX intermediary shall review the projections, make appropriate adjustments, and approve an interim rate.

(3) The facility or the Division may request an interim rate adjustment if the basis for the prospective rate has changed and a significant change in projected costs can be substantiated.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 3-1982(Temp), f. & ef. 3-3-82; MHD 8-1982, f. & ef. 5-3-82; MHD 10-1985, f. & ef. 6-13-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0190
Direct Care Staff

(1) The ICF/MR must insure that the staff are not diverted from their primary responsibilities by excessive housekeeping or clerical duties or other activities not related to resident care.

(2) Direct care staffing ratio:

(a) The following formulas are used to calculate the required number of staff when individuals are present in the facility. Changes to the direct care staffing ratio will only be made as part of a MHDDSD field audit for the purpose of determining 100 percent of an efficient and economically operated facility and determining the per diem reimbursement rate:

(A) "A" residents require a 1:2 staff to resident ratio computed as follows:

(i) 1st shift — 1:8;

(ii) 2nd shift — 1:8;

(iii) 3rd shift — 1:16.

(B) "B" residents require a 1:2.5 staff to resident ratio computed as follows:

(i) 1st shift — 1:16;

(ii) 2nd shift — 1:8;

(iii) 3rd shift — 1:16.

(C) "C" residents require a 1:5 staff to resident ratio computed as follows:

(i) 1st shift — 1:32;

(ii) 2nd shift — 1:16;

(iii) 3rd shift — 1:32.

(b) To determine full time equivalence (FTE) in any of the staffing ratios, compute the number of staff as described above and multiply the total by a posting factor of 1.63, e.g., in a facility with 16 "A" classified residents, a total of five staff would be required for each 24-hour period. Multiply a posting factor of 1.63 by five to get 1:2 FTE ratio or eight staff required to provide 24-hour service, seven days per week;

(c) The posting factor of 1.63 is based on a 365-day year, and assumes each staff member works five days per week, and has 12 holidays per year, 12 vacation days per year, and 12 sick days per year. Based on these figures, the average staff member works 224 days per year (52 weeks x 5 days — 36 days absent), which means another person must be on duty for 141 days in order to have one person on duty in that position for 365 days per year. One hundred forty-one is 63 percent of 224. Therefore in order to have one person on duty in a given position for 365 days of the year, there must be available one plus 0.63, or 1.63 individuals, one working 224 days and the other working 141 days per year.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:

Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 10-1985, f. & ef. 6-13-85; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0195
Year-End Settlement

(1) Settlement:

(a) The Division shall establish a year-end settlement rate on a retrospective basis for the period covered by the facility's cost statement and shall issue an official notice to the facility indicating the exact amount of the retroactive settlement;

(b) The year-end settlement rate shall be calculated as the lower of the ceiling rate or the actual net per diem cost as described in paragraphs (A) and (B) of this subsection:

(A) Ceiling rate: The facility's model budget rate will be revised to reflect the actual number and classification of residents for the period. The product of the resulting revised rate at 100 percent occupancy and the number of resident days at 100 percent occupancy shall be the ceiling amount in dollars. The quotient of the ceiling amount and actual resident days in the period will be the ceiling rate subject to the following modifications:

(i) If the facility is occupied at 95 percent or more of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and actual resident days in the period shall be the ceiling rate;

(ii) If the facility is occupied at less than 95 percent of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and product of 95 percent of the licensed bed capacity and the number of calendar days in the fiscal period shall be the ceiling rate.

(B) Actual net per diem cost. The quotient of actual costs, as adjusted in accordance with this rule, and actual resident days for the period shall be the actual net per diem cost.

(c) The dollar amount of the settlement shall be the sum of the 12 products of the monthly settlement rate (less the interim rate) and the respective monthly number of ICF/MR resident days (monthly settlement rate — monthly interim rate) x (monthly ICF/MR resident days):

(A) If the result of this calculation is positive, the dollar amount shall be paid by the Division to the facility;

(B) If the result of this calculation is negative, the dollar amount shall be paid by the facility to the Division;

(C) If the result of this calculation is zero, the Division's interim rate payment shall constitute full and complete payment.

(d) Vacancies described in OAR 309-043-0070 which are not prior authorized will not be allowed in the settlement process for Small and Large Residential Training Facilities.

(2) Settlement for FSRTFs:

(a) The Division shall establish a year-end settlement rate on a retrospective basis for the period covered by the facility's cost statement and shall issue an official notice to the facility indicating the exact amount of the retroactive settlement;

(b) The settlement for Full Service Residential Training Facilities shall be calculated as follows:

(A) Actual allowable costs. Actual allowable costs shall be actual costs for the period, adjusted in accordance with these rules;

(B) Reimbursable amount. The reimbursable amount shall be actual allowable costs;

(C) The dollar amount of the settlement shall be the reimbursable amount less total Title XIX interim payments less third party resource payment for the period:

(i) If the result of this calculation is positive, the dollar amount shall be paid by the Division to the facility;

(ii) If the result of this calculation is negative, the dollar amount shall be paid by the facility to the Division;

(iii) If the result of this calculation is zero, the Division's interim payments shall constitute full and complete payment.

(3) Costs above the ceiling amount. Costs above the ceiling amount may be allowed:

(a) When an individual admitted to and residing in a privately-operated ICF/MR needs diversion or crisis services as defined in OAR 309-041-0300 through 309-041-0335, Standards for Diversion/Crisis Services. In this situation, costs above the ceiling amount to prevent the individual from being admitted to a state-operated ICF/MR may be authorized by the Assistant Administrator for Developmental Disabilities. The costs will be reimbursed from State and Federal funds. Written prior approval from the Assistant Administrator for Developmental Disabilities must be obtained before funds are expended. Requests for reimbursement of costs above the ceiling amount must include the following information: Name of individual; definition of problems; explanation of why existing resources are insufficient to resolve the problem(s); description of goods and/or services to ameliorate the problem(s) including frequency, duration, and costs;

(b) When an individual not admitted to but residing in a privately-operated ICF/MR and occupying a vacant or reserved bed needs diversion or crisis services as defined in OAR 309-041-0300 through 309-041-0335. The facility in conjunction with the Individual Support Plan team will determine the appropriateness of serving a non-admitted individual. In this situation, any money received by the ICF/MR to prevent the individual from being admitted to a state-operated ICF/MR shall not be considered an offset to the ICF/MR payment as required by OAR 309-043-0080(7). The costs will be reimbursed from state funds. Written prior approval from the Assistant Administrator for Developmental Disabilities must be obtained before funds are expended. Requests for reimbursement of costs above the ceiling amount and without regard to OAR 309-043-0080(7) must contain the information described in subsection (a) of this section;

(c) When the costs are related to the approved plan for additional services as described in subsections (a) and (b) of this section. Documented costs must be submitted on an invoice and included with the facility's annual costs statement. These costs will be considered in the settlement process.

(4) Appeals. The Division shall notify the facility of the year-end settlement by certified letter. If the facility wishes to appeal the settlement, the facility shall so notify the Division in writing within 15 days of receipt of the letter of notification. Letters of appeal must be postmarked within the 15-day limit. Letters of appeal must be addressed to the Assistant Administrator for Administrative Services. The Assistant Administrator, Administrative Services, will forward all appeals to the Manager of the Mental Health and Developmental Disability Services Division's Audit Section for initial consideration. If no resolution is forthcoming, the provider will be given an opportunity for a fair hearing of the issues before the Assistant Administrator, Administrative Services.

(5) Monetary recovery, sanction, or other appeals. A provider may appeal the Division's proposed action by letter within the same 15-day period as allowed for appeals above: address this letter to the Assistant Administrator, Administrative Services.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 3-1982(Temp), f. & ef. 3-3-82; MHD 8-1982, f. & ef. 5-3-82; MHD 2-1990(Temp), f. & cert. ef. 1-26-90; MHD 10-1990, f. 7-17-90, cert. ef. 7-20-90; MHD 4-1994, f. & cert. ef. 4-27-94

309-043-0200
Base and Labor Costs

Facilities, except FSRTFs which may utilize the Medicare chart of accounts, shall use the following accounts to classify expenses on the ICF/MR Cost Statement.

(1) Base Costs: These accounts are for costs other than salaries and consulting fees:

(a) General and Administrative:

(A) Acct. 3310 — Office Supplies and Printing: All office supplies, printing, small equipment of an administrative use not requiring capitalization, postage, printed materials including manuals, and educational materials are to be included in this account;

(B) Acct. 3510 — Legal and Accounting: Legal fees applicable to the facility and attributable to resident care are to be included in this account. Retainer fees are not a specific resident related cost and shall be adjusted as non-allowable. Legal fees attributable to a specific resident shall be adjusted as non-allowable. Accounting and bookkeeping expenses of a non-duplicatory nature including accounting related data processing costs are also to be included in this account;

(C) Acct. 3520 — Management Fees: Management fees as defined in OAR 309-043-0155 are to be included in this account;

(D) Acct. 3530 — Donated Services: Donated services by non-paid workers as defined in OAR 309-043-0145 are to be included in this account;

(E) Acct. 3610 — Communications: Telephone and telegraph expenses are to be included in this account;

(F) Acct. 3711 — Travel — Motor Vehicle — Medical: This account includes medically related costs attributable to vehicle operation for facility and resident care use only. Personal use shall be separated from this account as an adjustment. Other expenses of auto insurance, repairs and maintenance, gas and oil, and reimbursement of actual employee expenses attributable to facility business should be included in this account. Auto allowances that are not documented by actual expenses will be reclassified to the appropriate salary or payroll account or adjusted as non-allowable expense;

(G) Acct. 3712 — Travel — Motor Vehicle — Non-Medical: This account includes the same kinds of costs described for Acct. 3711, Travel — Motor Vehicle — Medical, except they are not medically related;

(H) Acct. 3721 — Travel — Other — Medical: This account includes all medically related travel expenses not related to the use of a vehicle belonging to the facility or an employee, including board and room on business trips, airline and bus tickets. These expenses should be attributable to and related to resident care or this account should be adjusted for expenses attributable to non-resident care travel;

(I) Acct. 3722 — Travel — Other — Non-Medical: This account includes the same kinds of costs described for Acct. 3721, Travel — Other — Medical, except they are not medically related;

(J) Acct. 3809 — Other Interest Expense: Only interest not related to purchase of facility and equipment (including vehicles) is to be included in this account;

(K) Acct. 3810 — Advertising and Public Relations: Advertising and public relations expenses are to be included in this account;

(L) Acct. 3820 — Licenses and Dues: License and dues expenses are to be included in this account;

(M) Acct. 3830 — Bad Debts: Bad debts associated with Title XIX recipients are allowable. All other bad debts shall be adjusted as non-allowable;

(N) Acct. 3840 — Freight: This account includes shipping charges paid by the provider, unless they should be capitalized as part of a capital asset;

(O) Acct. 3910 — Miscellaneous: This account includes general and administrative expenses not otherwise includable in the General and Administrative Cost Area.

(b) Shelter:

(A) Acct. 4310 — Repair and Maintenance: This account contains all material costs entailed in the maintenance and repair of the building and departmental equipment;

(B) Acct. 4510 — Purchased Services: This account contains all expenses paid for outside services purchased in the maintenance and repair of a building, building equipment, and department equipment. It is also to include items such as lawn care by an outside service, security service, etc.;

(C) Acct. 4610 — Real Estate and Personal Property Taxes: Real estate and personal property tax expenses are to be included in this account;

(D) Acct. 4620 — Rent: Rent attributable to the lease of a facility is to be included in this account;

(E) Acct. 4630 — Lease: Lease expenses of equipment, vehicles, and other items separate from rent of a facility are to be included in this account;

(F) Acct. 4640 — Insurance: This account includes all insurance expenses except auto insurance, which should be classified under Travel — Motor Vehicle;

(G) Acct. 4710 — Depreciation — Land Improvements: See OAR 309-043-0115 and 309-043-1020 regarding capital assets and depreciation;

(H) Acct. 4720 — Depreciation — Building: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(I) Acct. 4730 — Depreciation — Building Equipment: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(J) Acct. 4740 — Depreciation — Moveable Equipment: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(K) Acct. 4750 — Depreciation — Leasehold Improvements: See OAR 309-043-0115 and 309-043-0120 regarding capital assets and depreciation;

(L) Acct. 4809 — Interest: Interest attributable to the purchase of facility and equipment is to be included in this account;

(M) Acct. 4910 — Miscellaneous: This account includes shelter expenses not otherwise includable in the Shelter Cost Area.

(c) Utilities:

(A) Acct. 5610 — Heating Oil: Heating oil expense is to be included in this account;

(B) Acct. 5620 — Gas: Gasoline for autos is to be included in Travel — Motor Vehicles. All other gasoline is to be included in this account;

(C) Acct. 5630 — Electricity: Electricity expense is to be included in this account;

(D) Acct. 5640 — Water, Sewage and Garbage: Water, sewage and garbage expenses are to be included in this account.

(d) Laundry:

(A) Acct. 6310 — Laundry Supplies: Laundry supplies expense is to be included in this account;

(B) Acct. 6315 — Linen and Bedding: Linen and bedding expense is to be including in this account;

(C) Acct. 6510 — Purchased Laundry Services: Laundry services purchased from an outside provider are to be included in this account;

(D) Acct. 6910 — Miscellaneous: This account includes laundry costs not otherwise includable in the laundry area.

(e) Housekeeping:

(A) Acct. 7310 — Housekeeping Supplies: Housekeeping supplies expense is to be included in this account;

(B) Acct. 7910 — Miscellaneous: This account includes housekeeping costs not otherwise includable in the Housekeeping Cost Area.

(f) Dietary:

(A) Acct. 8310 — Dietary Supplies: This account includes expenses associated with the serving of food, such as utensils, paper goods, dishware and other items. This account combines all the cost of prepared foods, meats, vegetables, and all manner of food ingredients and supplements. Expenses for candy, food or beverages sold through vending machines, commissary or snackbar are to be included in the expense account Concession Supplies;

(B) Acct. 8410 — Food;

(C) Acct. 8910 — Miscellaneous: This account includes dietary costs not otherwise includable in the Dietary Cost Area.

(g) Nursing Supplies and Services:

(A) Acct. 9310 — Nursing Supplies: This account includes cost of supplies used in nursing care covered in OAR 309-043-0045;

(B) Acct. 9320 — Drugs and Pharmaceuticals Non-RX: This account includes costs of drugs and pharmaceuticals defined in OAR 309-043-0045;

(C) Acct. 9330 — Drugs and Pharmaceuticals — RX: This account includes drug prescription costs defined in OAR 309-043-0050;

(D) Acct. 9351 — Pharmacy Services and Supplies: Pharmacy supplies and outside services expenses are to be included in this account;

(E) Acct. 9352 — Laboratory Services and Supplies: Laboratory Supplies and outside services expenses are to be included in this account;

(F) Acct. 9353 — X-Ray Services and Supplies: X-ray supplies and outside services expenses are to be included in this account;

(G) Acct. 9354 — Recreation Supplies and Services: Activities supplies and outside services expenses are to be included in this account;

(H) Acct. 9355 — Rehabilitation Supplies and Services: Rehabilitation supplies and outside services expenses are to be included in this account;

(I) Acct. 9510 — Physician Fees: Outside Physician fees are to be included in this account;

(J) Acct. 9530 — Day Treatment Supplies and Services: Only FSRTF are to use this account, which is to include day treatment supplies and services expense;

(K) Acct. 9950 — Concession Supplies: This account includes costs associated with vending machines and similar resale items;

(L) Acct. 9955 — Barber and Beauty Shop: This account includes barber and beauty related costs. Costs of services and supplies not meeting the definition in OAR 309-043-0045(2)(g), shall be adjusted;

(M) Acct. 9960 — Funeral and Cemetery: Funeral and cemetery expenses are to be included in this account;

(N) Acct. 9965 — Personal Purchases: This account includes the costs of all items purchased for resident care and excluded in the OAR 309-043-0045 as part of the all-inclusive rate unless specifically included in another account. These items would include, but not be limited to, incidental items defined in OAR 309-043-0060, authorized for payment from resident funds, and items not routinely furnished to all residents without additional costs;

(O) Acct. 9990 — Miscellaneous: This account includes miscellaneous supplies and services not otherwise includable in the Nursing Supplies and Services Cost Area.

(2) Labor Costs:

(a) Payroll Taxes and Employee Benefits: These accounts are to include all payroll taxes and employee benefits. The total net allowable payroll taxes and employee payroll and employee benefit account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll:

(A) Acct. 3200 — Total Employee Benefits and Taxes: This account is the total of Acct. 3210, Total Payroll Taxes, and Acct. 3220, Employee Benefits;

(B) Acct. 3210 — Total Payroll Taxes: This account includes the payroll taxes FICA, Acct. 3211; State Unemployment, Acct. 3212; Federal Unemployment, Acct. 3213; Worker's Compensation, Acct. 3214; Tri-Met, Acct. 3215; and any others;

(C) Acct. 3211 — FICA: This account includes the FICA tax;

(D) Acct. 3212 — State Unemployment: This account includes the state unemployment insurance tax;

(E) Acct. 3213 — Federal Unemployment: This account includes the federal unemployment insurance tax;

(F) Acct. 3214 — Worker's Compensation: This account includes the Worker's Compensation insurance tax;

(G) Acct. 3215 — Tri-Met: This account includes the Tri-Met payroll tax;

(H) Acct. 3216 — Payroll Tax — Other: Any amount showing in this account must be identified;

(I) Acct. 3220 — Employee Benefits: This account includes all employee benefits, and does not include payroll taxes for unemployment insurance and state accident insurance.

(b) Administrative Salaries:

(A) Acct. 3110 — Administrator Salary: This account includes all of the compensation received by the administrator. Other compensation including allowances and benefits not documented by specific costs, or similarly accruing to other employees of the facility are to be included in this account as a reclassification;

(B) Acct. 3231 — Employee Benefits and Taxes: This account includes employee taxes and benefits for the administrator, including employee insurance, vacation and sick pay, and other fringe benefits not otherwise accounted for. The costs in this account are to be allocated from the Acct. 3200, Total Employee Benefits and Taxes.

(c) Other Administrative Salaries:

(A) Acct. 3120 — Assistant Administrator Salary. This account includes all compensation received by the assistant administrator. The provisions applicable to the administrator compensation apply;

(B) Acct. 3130 — Salaries — Other Administrative. All clerical, receptionist, ward clerk, and medical records personnel salaries are to be included in this account. All home office payroll allowable to the facility is to be included in this account unless it is adequately demonstrated on an attachment to the cost statement that payroll amounts belong to another payroll account;

(C) Acct. 3132 — Employee Benefits and Taxes. This account includes benefits and taxes for the other administrative personnel. The costs in this account are to be allocated from Acct. 3200, total employee benefits and taxes.

(d) Nursing Salaries:

(A) Acct. 9110 — Salaries — DNS: Director of Nursing Services salary is to be included in this account;

(B) Acct. 9111 — Salaries — RN: Registered Nurse salaries are to be included in this account;

(C) Acct. 9112 — Salaries — LPN: Licensed Practical Nurse and Licensed Vocational Nurse salaries are to be included in this account;

(D) Acct. 9291 — Employee Benefits and Taxes: This account shall include employee benefits and taxes for the DNS, RNs, and LPNs. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(e) Direct Care Salaries:

(A) Acct. 9122 — Salaries — Direct Care: Salaries for the facility's living unit personnel who train residents in activities of daily living and in the development of self-help and social skills are included in this account. This does not include salaries for other professional services included under active treatment services;

(B) Acct. 9123 — Salaries — Direct Care Supervisors: Salaries for direct care supervisors;

(C) Acct. 9124 — Salaries — Secure Ward Staff: Salaries for secure ward staff;

(D) Acct. 9125 — Salaries — Secure Ward Supervisors: Salaries for secure ward supervisors;

(E) Acct. 9292 — Employee Benefits and Taxes: This account includes employee benefits and taxes for direct care staff. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(f) Other Salaries:

(A) Acct. 4110 — Repair and Maintenance Salaries: This account includes payroll for services related to repair, maintenance and plant operation;

(B) Acct. 6110 — Laundry Salaries: Laundry salaries are to be included in this account;

(C) Acct. 7110 — Housekeeping Salaries: Janitorial salaries and housekeeping salaries are to be included in this account;

(D) Acct. 8110 — Dietary Salaries: Dietary salaries are to be included in this account;

(E) Acct. 9130 — Salaries — Physician: Physician salaries, exclusive of physician fees and consulting services, are to be included in this account;

(F) Acct. 9131 — Salaries — Pharmacy: Pharmacy salaries are to be included in this account;

(G) Acct. 9132 — Salaries — Laboratory: Laboratory salaries are to be included in this account;

(H) Acct. 9133 — Salaries — X-Ray: X-ray salaries are to be included in this account;

(I) Acct. 9134 — Salaries — Activities (Occupational): Activities (occupational) salaries are to be included in this account;

(J) Acct. 9135 — Salaries — Rehabilitation: Rehabilitation salaries are to be placed in this account;

(K) Acct. 9140 — Salaries — Religious: Religious salaries are to be included in this account;

(L) Acct. 9148 — Salaries — Receiving Warehouse: Only receiving warehouse salaries incurred by FSRTF's are to be included in this account;

(M) Acct. 9149 — Salaries — Other: This account includes Nursing Service Salaries not otherwise includable in the Nursing Service Cost Area. Purchased nursing services are to also be included in this account;

(N) Acct. 9296 — Employee Benefits and Taxes: This account includes benefits and taxes for the employee listed in the cost category. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(g) Active Treatment Services: These accounts include all special programs except Day Program service costs incurred by FSRTFs, and professional medical services, except Medical Service costs incurred by FSRTFs. Included are costs for consultation, treatment and evaluations not paid for separately by CAF. Expenses not required for certification shall be adjusted as non-allowable:

(A) Acct. 9150 — Qualified Mental Retardation Professional;

(B) Acct. 9151 — Registered Nurse Consultant (SRTF only);

(C) Acct. 9152 — Psychologist;

(D) Acct. 9153 — Social Worker;

(E) Acct. 9154 — Speech Therapist;

(F) Acct. 9156 — Occupational Therapist;

(G) Acct. 9157 — Recreation Therapist;

(H) Acct. 9158 — Physical Therapist;

(I) Acct. 9159 — Dietician;

(J) Acct. 9160 — Dentist;

(K) Acct. 9161 — Pharmacist;

(L) Acct. 9162 — Skill Trainer/Program Coordinator (Skill Trainer in SRTF only);

(M) Acct. 9170 — Other Medical Consultants;

(N) Acct. 9297 — Employee Benefits and Taxes: This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(h) Medical Services: These accounts include only medical service program costs incurred by FSRTFs:

(A) Acct. 9180 — Physician Services;

(B) Acct. 9181 — Pharmacy Services;

(C) Acct. 9182 — Laboratory Services;

(D) Acct. 9183 — X-Ray Services;

(E) Acct. 9186 — Nursing Services;

(F) Acct. 9187 — Dental Services;

(G) Acct. 9188 — Central Supply Services;

(H) Acct. 9298 — Employee Benefits and Taxes: This account includes benefits and taxes for the employee included in this cost category. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

(i) Day Program Services: These accounts include only Day Program service costs incurred by FSRTFs:

(A) Acct. 9190 — Day Program Services;

(B) Acct. 9299 — Employee Benefits and Taxes: This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. 3200, Total Employee Benefits and Taxes.

Stat. Auth.: ORS 179 & 430
Stats. Implemented:
Hist.: MHD 4-1981(Temp), f. & ef. 6-30-81; MHD 8-1981, f. & ef. 12-11-81; MHD 4-1994, f. & cert. ef. 4-27-94

Residential Training Centers

309-043-0230
Statement of Purpose, Mission Statement, and Statutory Authority

(1) Purpose. These rules prescribe standards by which the Mental Health and Developmental Disability Services Division licenses Residential Training Centers (RTC) that provide 24 hour residential support services for individuals with developmental disabilities and are certified as Intermediate Care Facilities for the mentally retarded in accordance with federal standards.

(2) Mission Statement. The overall mission of the State of Oregon Mental Health and Developmental Disability Services Division is to provide support services that will enhance the quality of life of persons with developmental disabilities. RTC services are one element within the service delivery system and are critical to achieving this mission. The overall purpose of the RTC's Administrative Rule is to ensure that RTCs meet basic management, programmatic, health and safety, and human rights regulations. RTCs are responsible for developing and implementing policies and procedures and/or plans that ensure that the requirements of the rule are met. In addition, RTCs must ensure compliance with all applicable local, state and federal laws and regulations which apply to the type of services they provide.

(3) Statutory Authority. These rules are authorized by ORS 430.041 and 443.400 through 433.455 and carry out the provisions of **42 CFR Part 483, Subpart I**.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0240
Definitions

As used in these rules, the following definitions apply:

(1) "Abuse" as defined in OAR 309-116-0005(1) means any act or absence of action inconsistent with prescribed client treatment that violates the well being or dignity of the individual. This includes but is not limited to:

(a) Physical assault such as hitting, kicking, scratching, pinching or pushing;

(b) Neglect of care of the individual causing physical or psychological harm or significant risk of harm;

(c) Denying meals, clothing or aids to physical functioning;

(d) Use of derogatory or inappropriate names, phrases, profanity, ridicule, harassment, coercion, threats, cursing or intimidation;

(e) Sexual exploitation of individuals including inappropriate physical contact between staff and individuals served, or failure of staff to discourage sexual advances towards staff by individuals served;

(f) Condoning or permitting abuse of an individual by any other person including other clients; or

(g) Other similar acts or omissions.

(2) "Administration of Medication" means the act of a staff member, who is responsible for the individual's care, of placing a medication in, or on, an individual's body.

(3) "Advocate" means a person other than paid staff who has been selected by the individual or by the individual's legal representative to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(4) "Aid to Physical Functioning" means any special equipment prescribed for an individual by a physician, therapist, or dietitian which maintains or enhances the individual's physical functioning.

(5) "Complaint" means any allegation made to a proper authority that the RTC has taken an action which is alleged to be contrary to law, rules or policy.

(6) "Controlled Substance" means any drug classified as Schedules 1 through 5 under the Federal Controlled Substance Act.

(7) "Developmental Disability" means a disability attributable to mental retardation, autism, cerebral palsy, epilepsy or other neurological handicapping condition which requires training or support similar to that required by individuals with mental retardation, and the disability:

(a) Originates before the individual attains the age of 22 years, except that in the case of mental retardation the condition must be manifested before the age of 18; and

(b) Has continued, or can be expected to continue, indefinitely; and

(c) Constitutes a substantial handicap to the ability of the person to function in society; or

(d) Results in significant subaverage general intellectual functioning with concurrent deficits in adaptive behavior which are manifested during the developmental period. Individuals of borderline in intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classification shall be consistent with the **"Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision.** Mental retardation is synonymous with mental deficiency.

(8) "Director" means the individual responsible for administration of the RTC program and provision of support services for individuals.

(9) "Division" means the Mental Health and Developmental Disability Services Division.

(10) "Entry" means admission to an RTC.

(11) "Exit" means termination from an RTC. Exit does not mean transfer from within the RTC.

(12) "Financial Exploitation" means mismanagement of individual's funds which may include, but is not limited to, unauthorized rate increases, borrowing from or loaning money to individuals, witnessing wills in which the RTC is beneficiary, adding RTC's name to the individual's bank accounts or other personal property, inappropriately expending individual's personal funds, commingling individual's funds with RTC or other individuals' funds, or the RTC becoming guardian or conservator.

(13) "Grievance" means any allegation made by a staff member, individual, or guardian of an individual on behalf of the individual, that the RTC participated in or allowed to happen, any action other than abuse which is alleged to or be contrary to rule or policy.

(14) "Health Care Plan" means a plan developed by the physician, in coordination with licensed nursing personnel, which addresses the health needs of individuals who are ill or medically at risk and require 24-hour licensed nursing care.

(15) "Incident Report" means a written report of any injury, death, accident, unusual acts of physical aggression or physical aggression resulting in injury, or other unusual incident involving an individual.

(16) "Individual" means a person with developmental disabilities for whom services are planned and provided by the RTC.

(17) "Integration" is defined in ORS 427.005 as

"**the use by persons with mental retardation or developmental disabilities of the same community resources that are used by and available to other persons and participation in the same community activities in which non-handicapped persons participate, together with regular contact with non-handicapped persons, and residence by persons with developmental disabilities in homes or in home-like settings which are in proximity to community resources, together with regular contact with non-handicapped persons in their community**."

(18) "IDT" means the individual's Interdisciplinary Team.

(19) "Intermediate Care Facility for the Mentally Retarded" means an establishment which is licensed by the state to provide training and care to mentally retarded persons or persons with related conditions and certified by the State as an ICF/MR under Title XIX of the Social Security Act.

(20) "Legal Representative" means the parent, if the individual is under age 18, unless the court appoints another individual or agency to act as guardian. For those individuals over the age of 18 a legal representative means an attorney at law, or a person who is authorized by a court to make decisions about services for the individual.

(21) "License" means a document issued by the Mental Health and Developmental Disability Services Division to providers of RTC services which verifies that the provider is eligible to provide such services and to receive funds for these services.

(22) "Licensee" means a person or organization to whom a license is granted.

(23) "Licensing Checklist" means a checklist of Administrative Rules completed by the RTC to determine its compliance with minimum standards.

(24) "Medication" means any drug, chemical, compound, suspension or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(25) "MHDDSD" means the Mental Health and Developmental Disability Services Division.

(26) "Office of Developmental Disability Services" or "DD Office" means the Office of Developmental Disabilities Services of the Mental Health and Developmental Disability Services Division.

(27) "Physical Restraint" means restricting the movement of an individual or restricting the movement or normal function of a portion of the individual's body.

(28) "Plan of Improvement" means a plan developed by the RTC following completion of the licensing checklist that addresses specific activities and benchmarks for those areas identified by the RTC as not in compliance with Administrative Rules.

(29) "Protection" means the necessary actions taken by an RTC to prevent abuse or exploitation of the individual, to prevent self-destructive acts, and to safeguard an individual's person, property and funds.

(30) "Protective Services" means an investigation and may include subsequent services provided in response to complaints of abuse, neglect or exploitation of individuals who are eighteen years of age or older and are unable to protect their own interests.

(31) "Psychotropic Medication" is defined as a medication whose prescribed intent is to affect or alter thought processes, mood, or behavior. This includes, but is not limited to, anti-psychotic, antidepressants, anxiolytic (anti-anxiety), and behavior medications. Because a medication may have many different effects, its classification depends upon its stated, intended effect when prescribed.

(32) "Residential Training Center" or "RTC" means a residential training facility serving 25 or more individuals in one or more buildings on contiguous property.

(33) "Self-Administration of Medication" means the individual manages and takes his/her own medications. It includes identifying his/her medication, and the times and methods of administration, placing the medication internally in, or externally on, his or her own body without staff assistance, upon the written order of a physician, and safely maintaining the medication(s) without supervision.

(34) "Self-Assessment" means a process by which an RTC assesses their services against a set of Administrative Rule standards, and identifies and determines level of compliance and areas within the program in need of improvement.

(35) "Staff" means a paid employee of the RTC responsible for providing support and training services to individuals.

(36) "Support" means those ancillary services other than direct training which may include, but are not limited to, assisting an individual to maintain skill competencies, achieve community access and social integration, enhance productivity, increase independent functioning and enjoy a satisfying lifestyle.

(37) "Training" means the planned sequence of systematic interactions, activities, structured learning situations, or educational experiences designed to meet each individual's specific needs.

(38) "Unusual Incident" means unexpected events where there is a substantial risk of harm to the individual. These may include, but are not limited to, a sudden change in medical condition, suicide threat/attempt, attempted arson, accidents resulting in injury or risk of injury, or incidents requiring a protective services/abuse investigation.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0250
Issuance of License

(1) License required. No person or governmental unit acting individually or jointly with any other person or governmental unit shall establish, conduct, maintain, manage or operate an RTC without being licensed.

(2) Not transferable. Each license is issued only for the premises and persons or governmental units named in the application and shall not be transferable or assignable.

(3) Terms of license. Each license is issued for a maximum of two years.

(4) RTC review. Prior to the issuance of the license the RTC shall conduct a self-assessment based upon the requirements of this rule:

(a) The RTC shall document the self-assessment information on forms provided by the DD Office;

(b) The RTC shall develop and implement a plan of improvement based upon the findings of the self-assessment; and

(c) The RTC shall submit these documents to the DD Office.

(5) DD Office review. The DD Office shall conduct a review of the RTC within 12 months of receipt of the self-assessment and plan of improvement. The review may be complete or partial at the discretion of the DD Office.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0260
Application for Initial License and License Renewals

(1) Form. The application shall be on a form provided by the Division and shall include all information requested by the Division.

(2) Initial application. The applicant shall identify the number of individuals to be served initially by the RTC.

(3) Renewal application. To renew licensure, the RTC shall make application at least 30 days prior to the expiration date. On renewal, no increase in the number of individuals to be served shall be licensed unless specifically approved by the Division.

(4) Renewal application extends expiration date. Filing of an application for renewal at least 30 days prior to the expiration date of the license extends the effective date until the Division takes action upon such application.

(5) Incomplete or incorrect information. Failure to disclose requested information on the application or provision of incomplete or incorrect information on the application or if the State Fire Marshal or his authorized representative has given notice of non-compliance, may result in denial or revocation of the license.

(6) Demonstrated capability. Prior to issuance of the license the applicant must demonstrate to the satisfaction of the Division that the applicant is in substantial compliance with the requirements of OAR 309-043-0230 through 309-043-0580.

(7) Separate buildings. Separate licenses are not required for separate buildings located contiguously and operated as an integrated unit by the same management.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0270
License Expiration Termination of Operations, License Return

(1) Expiration. Unless revoked or terminated earlier, each license to operate an RTC shall expire on the expiration date specified on the

license, unless the license is extended by the timely filing of an application for renewal. See OAR 309-043-0260(4).

(2) Termination of operation. If an RTC operation is discontinued, the license shall be considered to have been terminated.

(3) Return of license. Each license in the possession of the RTC shall be returned to the Division immediately upon suspension or revocation of the license, or when operation is discontinued by the holder of the license.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0280
Change of Ownership, Legal Entity, Legal Status, Management Corporation

(1) Notice of pending change in ownership, legal entity, legal status or management corporation. The RTC shall notify the Division in writing of any pending change in ownership or legal entity, legal status or management corporation.

(2) New license required. A new license shall be required upon change in ownership/legal entity or legal status. The RTC shall submit a license application at least 30 days prior to change in ownership/legal entity or legal status.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0290
Inspections and Investigations

(1) Inspections and investigations required. All services covered by this rule shall allow the following types of investigations and inspections:

(a) Quality assurance, license renewal and on-site inspections;

(b) State Fire Marshal inspections;

(c) Complaint investigations; and

(d) Abuse investigations.

(2) Inspections and investigations by the Division, its designee or proper authority. All inspections and investigations shall be performed by the Division, its designee, or proper authority.

(3) Unannounced. Any inspection or investigation may be unannounced.

(4) Required documentation. All documentation and written reports required by this rule shall be:

(a) Open to inspection and investigation by the Division, its designee or proper authority; and

(b) Submitted to the Division within the time allotted.

(5) Priority of investigation under subsections (1)(c) through (d) of this rule. When the Division has determined to initiate an investigation pursuant to subsections (1)(c) through (d) of this rule, the RTC shall receive authorization from the Division before conducting any internal investigation. The RTC may continue to conduct necessary personnel action as required by OAR 309-043-0350(1).

(6) Plan of improvement. A plan of improvement shall be submitted to the Division for any noncompliance found during an inspection or investigation under the rule within the time period required by the Division.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0300
Alternative Methods, Variances

(1) Criteria for a variance. Variances may be granted to an RTC when implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules, unless a variance in the particular situation would violate state or federal law.

(2) Variance application. The RTC requesting a variance shall submit, in writing, an application to the DD Office which contains the following:

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

(b) The reason for the proposed variance;

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

(d) A description of the individual's opinion and participation in requesting the variance; and

(e) A plan and timetable for compliance with the section of the rule from which the variance is sought.

(3) Office of Developmental Disability Services review. The Assistant Administrator or designee of the DD Office shall approve or deny the request for a variance.

(4) Notification. The DD Office shall notify the RTC of the decision. This notice shall be sent within 30 days of the receipt by the DD Office with a copy to other relevant sections of the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Duration of variance. The duration of the variance shall be determined by the DD Office.

(7) Written approval. The RTC may implement a variance only after written approval from the Division.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0310
Health: Medical Services

(1) Confidentiality. All individuals' medical records shall be kept confidential as described in OAR 309-043-0440(1) and (2).

(2) Written policies and procedures. The RTC shall have and implement written policies and procedures which describe release of any individual's information, and how the medical management system operates including medication administration, self-administration and medication reviews, emergency medical procedures, administrative review of medication irregularities, confidentiality of medical records and drug disposal.

(3) Individual care. Individuals shall receive care that promotes their health and well-being, as follows:

(a) Individuals shall have a primary physician;

(b) Provisions shall be made for a secondary physician/clinic in the event of an emergency;

(c) The RTC shall assure that individuals are examined annually by a physician, and results of the examination shall be placed in the individual's record;

(d) The RTC shall monitor the health status and physical conditions of individuals and take action in a timely manner in response to identified changes in conditions that could lead to deterioration or harm;

(e) The RTC shall assist individuals with the use and maintenance of prosthetic devices as ordered; and

(f) When indicated by physical examination or IDT determination, the RTC shall assure that consultations by specialists/professionals are obtained.

(4) Documentation. The RTC shall maintain records on each individual to aid physicians, medical professionals and the RTC in understanding the individual's medical history and current treatment program. These records shall be kept current and organized in a manner that permits staff and medical persons to follow easily the individual's course of treatment. Such documentation shall include:

(a) A medical history provided prior to entry to the RTC that includes, where available:

(A) The results of a current valid physical exam prior to entry and the findings of a TB test made within two weeks of entry;

(B) Results of any dental evaluation;

(C) A record of immunizations;

(D) Status of Hepatitis B screening; and

(E) A record of known communicable diseases and allergies.

(b) Within 30 days after admission, the results of a comprehensive assessment or reassessment of physical development and health, nutritional status and sensorimotor development shall be available;

(c) Information on health care which includes:

(A) Current medical conditions;

(B) A record of all current orders for medications, treatments, special diets and prosthetic devices; and

(C) A record of visits to medical professionals and any consultation or therapy provided.

(d) Within 30 days of admission a Health Care Plan shall be present and integrated in the IPP for individuals in need of 24 hour licensed nursing care as determined by a physician. For individuals certified as not needing a Health Care Plan, an annual nursing assess-

ment, and quarterly physical examination of health care status conducted by a licensed nurse shall be present and result in any action indicated by the examination findings.

(5) Written physician's order. All medications, treatments, diets and therapies shall:

(a) Have a written order, signed by a physician or physician designee, before any medication, prescription or non-prescription, regularly scheduled or PRN (i.e., as needed), is administered to or self-administered by an individual; and

(b) Be followed per written orders.

(6) PRN/Psychotropic medication prohibited. Standing PRN orders shall not be allowed for psychotropic medication.

(7) Requirements for medications. All medications and biologicals shall be:

(a) Properly labeled;

(b) Kept in a secured locked container and stored as prescribed; and

(c) Recorded on an individualized Medication and or Treatment Administration Record (MAR/TAR) including treatments and PRN orders. The MAR/TAR shall include:

(A) The name of the individual;

(B) The brand name and/or generic name of the medication, including the prescribed dosage and frequency of administration as contained on the physician order;

(C) Times and dates of administration or self-administration of the medication;

(D) The signature of the staff administering the medication or monitoring the self-administration of the medication;

(E) Method of administration;

(F) Documentation of any adverse reactions to the medication;

(G) Documentation and an explanation of why a PRN medication was administered and the results of such administration; and

(H) An explanation of any medication administration irregularity with documentation of administrative review.

(8) Adverse effects safeguards. Safeguards to prevent adverse medication reactions shall be utilized that include:

(a) Obtaining all prescription medications for each individual from a single pharmacy (except in the case of an after hours emergency), which maintains a medication profile for him or her;

(b) Reviewing each individual's medications at least every 90 days by a pharmacist. Medication reviews shall include an analysis of all medications, potential side-effects or contraindications and identifying potential irregularities;

(c) Maintaining information about each prescribed medication's effects and side-effects; and

(d) Assuring that medications prescribed for one individual shall not be administered to, or self-administered by, another individual or staff member.

(9) Unused, outdated or recalled drugs. No unused, outdated, or recalled drugs shall be kept in the residence. All unused, outdated, or recalled controlled substances shall be disposed of in a manner consistent with federal statutes and designed to prevent the illegal diversion of these substances into the possession of people other than for whom it was prescribed. A written record shall be maintained by the RTC of all disposed drugs and shall include:

(a) A description of the drug, including amount;

(b) The individual for whom the medication was prescribed;

(c) The reason for disposal;

(d) The method of disposal; and

(e) Signature of staff disposing.

(10) Self-administration of medication. For any individual who is self-administering medication the RTC must:

(a) Have documentation that a training program was initiated with approval of the individual's IDT team and physician (signed physician order required) or that training for the individual is unnecessary (signed physician order required);

(b) Have a training program that provides for retraining when there is a change in dosage, medication and/or time of delivery; and

(c) Provide for a review, yearly at a minimum, as part of the IPP process, upon completion of the training program.

(11) Self-administration medications locked. The RTC shall assure that individuals able to self-administer medications keep them in a locked place accessible to the individual but unavailable to other individuals residing in the same residence and store them as prescribed.

(12) Nursing care. The RTC shall assure licensed nursing services that are:

(a) Sufficient to care for individuals' health needs including those with a Health Care Plan; and

(b) In accordance with standard and scope of practice for any licensed practical nurse and registered nurse.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0320
Health: Food and Nutrition

(1) Well-balanced and nourishing diet. A nourishing well-balanced diet shall be provided to all individuals in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, or physician's order.

(2) Modified, special diets. All modified or special diets shall be ordered by a physician.

(3) Registered dietitian. A dietitian, registered by the American Dietetic Association, shall be employed either full-time, part-time or on a consultant basis.

(4) Number of meals. At least three meals shall be provided for or arranged daily.

(5) Need and preference of individual. Foods shall be served in a form consistent with the individual's need, while providing him/her with opportunities for choice in food selection.

(6) Dining areas and staff supervision. The RTC shall:

(a) Serve meals for all individuals in dining areas unless otherwise specified by the IDT team or a physician;

(b) Provide dining areas with chairs, tables, eating utensils and dishes designed to meet the developmental needs of each individual; and

(c) Staff shall supervise dining rooms adequately to assure individuals receive enough food and beverages; and eat in a manner consistent with his or her developmental level.

(7) Special diets and menu requirements. Menus including special diets shall:

(a) Be prepared a week in advance;

(b) Provide a sufficient variety of foods;

(c) Be adjusted for seasonal change;

(d) Be retained for at least 30 days; and

(e) Indicate any modifications made.

(8) Food and supplies on hand. There shall be adequate food and supplies maintained in the RTC with at least a two days supply of perishable fruits and vegetables and a week's supply of staple foods.

(9) Prohibited food items. Raw milk and home canned vegetables, meat and fish shall not be served or stored at the RTC.

(10) Temperature and sanitation. Food shall be prepared, served and stored at proper temperatures and in a sanitary manner.

(11) Utensils and dishes. All utensils, including dishes, glassware and silverware, used in the serving or preparation of food or drink for individuals shall be:

(a) Thoroughly washed and rinsed after each use; and

(b) Stored in such a manner as to assure that they are kept free of dust, insects and contamination.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0330
Health: Physical Environment

(1) Clean and in good repair. All floors, walls, ceilings, windows, furniture and fixtures shall be kept in good repair, clean and free from odors.

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

(3) Room temperature. The temperature within the residence shall be maintained within a normal comfort range.

(4) Insects and rodents. All measures necessary shall be taken to prevent the entry of insects and rodents.

(5) Garbage. The interior and exterior of the residence shall be kept free of litter, garbage and refuse.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0340
Safety: General

(1) Physical attributes of RTC's. All physical attributes of these facilities shall comply with the Occupational Health and Safety Act, the **Uniform Building Code, Uniform Mechanical Code, National Electrical Code, Uniform Fire Code**, and the **National Fire Protection Association 101 Life Safety Code** for whichever is the most restrictive.

(2) Window coverings for privacy. Window shades, curtains, or other coverings shall be provided on all bedroom and bathroom windows to assure privacy.

(3) Hot water temperature. Hot water except for dishwashers and washing machines shall not exceed 110 degrees F.

(4) Flashlights. Operative flashlights, at least one per floor, shall be readily available to staff in case of emergency.

(5) First-aid kit and manual. First-aid kits and first-aid manuals shall be readily available to staff in case of an emergency.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0350
Safety: Personnel

(1) Basic personnel policies and procedures. The RTC shall have in place personnel policies and procedures which address disciplinary and/or termination from employment procedures when a staff member, through action or inaction, endangers the health, safety or welfare of individuals.

(2) Director qualifications. The RTC shall be operated under the supervision of a Director/Superintendent who has a minimum of a bachelor's degree and four years experience, including supervision, in a related field; or eight years of experience, including supervision, in the field of developmental disabilities or a social service/mental health field. The eight years experience shall include four years of management experience in a public or private organization which included responsibility for:

(a) Development of program rules and policies;

(b) Development of long- and short-range goals and plans;

(c) Program evaluation; and

(d) Budget preparation;

(e) Graduate-level courses in management may be substituted for one year of the required experience.

(3) Staff qualifications. Any staff who supervise individuals shall be at least 18 years of age and capable of performing the duties of the job as described in a current job description which he/she signed and dated.

(4) CPR and first aid. The RTC shall have at least one staff, who has been certified to give CPR and First Aid by a recognized training agency, available on the premises of each residence when individuals are present.

(5) Personnel files. The RTC shall maintain a personnel file on each staff person. In addition, the RTC shall maintain the following information on each staff person in a file available to the Division or its designee for inspection:

(a) Written documentation that references and qualifications were checked;

(b) Written documentation of a criminal record clearance by the Division;

(c) Written documentation of a TB test upon hiring;

(d) Written documentation of any substantiated abuse allegation/complaints filed against the staff person and the results of the grievance process, including, if any, disciplinary action; and

(e) Written documentation of any licenses required to perform duties.

(6) Training records. The RTC shall maintain a training record on each staff person that includes:

(a) CPR and first-aid certification, as applicable, obtained within six months of employment and kept current;

(b) The facility must provide each employee with initial training focusing on skills and competencies directed toward clients' developmental, behavioral, and health needs that enables the employee to perform his or her duties effectively, efficiently, and competently; and

(c) The facility must provide each employee with continuing training focusing on skills and competencies directed toward clients' developmental, behavioral, and health needs that enables the employee to perform his or her duties effectively, efficiently, and competently.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0360
Safety: Staffing Requirements

(1) Facility professional staffing requirements. Each individual shall receive the professional program services needed to implement the individual's program plan:

(a) Each individual's program plan shall be integrated, coordinated and monitored by a qualified mental retardation professional;

(b) The RTC shall have available enough qualified professional staff to carry out and monitor the various professional interventions stated in every individual's program plan;

(c) Professional staff shall participate as members of the IDT in relevant aspects of the individual's program plan;

(d) Professional staff shall participate in ongoing staff development and training;

(e) The RTC shall maintain proof of required license, registration or certification of professional staff upon employment and at required intervals.

(2) General staffing requirements. Each RTC shall provide staff appropriate to the number of individuals served, as follows:

(a) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when individuals are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing.

(b) The RTC shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary care duties.

(3) Direct care (residential living unit) staff. The RTC shall provide sufficient direct care staff present and on duty to manage and supervise individuals in accordance with their individual program plan. Direct care staff shall be provided by the RTC in the following minimum ratios calculated over all shifts in a 24 hour period for each residential unit:

(a) For each defined residential living unit serving individuals who are profoundly disabled, have severe physical disabilities, or who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior the staff ratio is 1 to 3.2;

(b) For each defined residential living unit serving individuals with moderate disabilities, the staff ratio is 1 to 4;

(c) For each defined residential living unit serving individuals within the range of mild disabilities, the staff ratio of 1 to 6.4; and

(d) When there are no individuals present on the living unit, a responsible staff member shall be available by telephone.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0370
Safety: Individual Records

A record shall be maintained for each individual receiving services from the RTC. The record shall include:

(1) The individual's name, previous address, date of entry into the facility, date of birth, sex, marital status, social security number, social security beneficiary account number, religious preference, preferred hospital, CAF number where applicable, guardianship status; and

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

(a) The individual's legal representative, family, advocate or other significant person;

(b) The individual's preferred physician;

(c) The individual's preferred dentist;

(d) The individual's day program, or employer, if any;

(e) Other agency representatives providing services to the individual.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0380
Safety: Incident Reports and Emergency Notifications

(1) Incident reports. Written incident reports shall be maintained by the RTC. Sufficient documentation shall be maintained in the individual's record so that the report can be retrieved by licensing teams, certification surveyors, and other authorized individuals. Such description shall include:

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

(b) A description of the incident;

(c) Staff response at the time; and

(d) Administrative review and follow-up.

(2) Immediate notification. In the case of a serious illness, accident, death or abuse of an individual, the RTC shall immediately notify:

(a) The individual's legal guardian or conservator, parent, next of kin or other significant person; and

(b) Any agency responsible for the individual.

(3) Missing notification. In the case of an individual who is missing, absent without supervision beyond the timeframes established by the IDT, the RTC shall immediately notify:

(a) The individual's guardian, if any, or nearest responsible relative;

(b) The appropriate police jurisdiction; and

(c) Any agency responsible for the individual.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0390
Safety: Vehicles and Drivers

Vehicles operated by the RTC that transport individuals shall:

(1) Maintain the vehicles in a safe operating condition;

(2) Comply with Department of Motor Vehicles laws;

(3) Maintain insurance coverage; and

(4) Carry in vehicles a fire extinguisher, Universal Precaution Kit, and first-aid kit.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0400
Safety: Emergency Plan and Safety Review

(1) Written plan. A written emergency plan shall be developed and implemented and shall include instructions for staff in the event of fire, explosion, accident, or other emergency including evacuation of individuals served.

(2) Posting of emergency information. Emergency telephone numbers shall be posted as follows:

(a) The telephone numbers of the local fire, police department and ambulance service, if not served by a 911 or other special emergency service, TTY numbers or OTRS relay number (if applicable), posted by the staff telephone; and

(b) The telephone number of the administrator, emergency physician and other persons to be contacted in case of an emergency posted by the staff telephone.

(3) Monthly safety review. A documented safety review shall be conducted monthly to assure that the residence is free of hazards. These reports shall be kept by the RTC for three years.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0410
Safety: General Fire Training Requirements

(1) Training. The RTC shall train all individuals immediately upon entry to leave the residence in response to an alarm and to cooperate with assistance to exit the residence.

(2) Level of license. To ensure that fire safety requirements can be met, the residence shall not admit individuals functioning below the level indicated on the license.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0420
Safety: Evacuation Drills and Fire Safety

(1) General drill requirements. Each residence shall conduct monthly fire drills:

(a) At least once every three months the drill will be conducted during normal sleeping hours;

(b) Exit routes shall vary based on the location of a simulated fire;

(c) Any individual failing to evacuate the residence unassisted within the established time limits for the RTC shall be provided specialized training in evacuation procedures which shall be included in their IPP;

(d) Written documentation shall be made at the time of the drill, kept by the RTC for at least two years following the drill. It shall include:

(A) The date and time of the drill;

(B) The location of the simulated fire;

(C) The number of staff present on the premises at the time of the drill and the number of individuals evacuated;

(D) The amount of time required to evacuate the building;

(E) Notation of any individual with problems in evacuating the premises; and

(F) The signature of the staff conducting the drill.

(2) Drill requirements for individuals residing at the RTC who are medically fragile or have severe physical limitations. In RTCs providing services to individuals who are medically fragile or have severe physical limitations, requirements of fire drill conduct may be modified. The modified plan shall:

(a) Be developed with the local fire authority, the administrator; and

(b) Be presented as a variance request per OAR 309-043-0300.

(3) Fire detectors and protection equipment. Fire detectors and protection equipment shall be inspected and documentation of inspections maintained as recommended by the State Fire Marshal.

(4) Adaptations required for sensory or physically impaired. The RTC shall provide necessary adaptations to ensure fire safety for sensory and physically impaired individuals.

(5) State and local codes. The RTC shall comply with all applicable state and local building, electrical, plumbing and zoning codes appropriate to the individuals served.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0430
Rights: General

(1) Policies and procedures. The program shall have and implement written policies and procedures which protect individuals' rights and encourage and assist individuals to understand and exercise these rights. These policies and procedures shall at a minimum provide for:

(a) Assurance that each individual has the same civil and human rights accorded to other citizens;

(b) Adequate food, housing, clothing, medical and health care, supportive services and training;

(c) Visits to and from family members, friends, advocates, and when necessary legal and medical professionals;

(d) Confidential communication including personal mail and telephone;

(e) Personal property and fostering of personal control and freedom regarding that property;

(f) Privacy;

(g) Protection from abuse and neglect;

(h) Freedom from unauthorized training, treatment and physical restraints or drugs in doses that interfere with daily living activities;

(i) Freedom to choose whether or not to participate in religious activity;

(j) The opportunity to vote and training in the voting process;

(k) Expression of sexuality, to marry and to have children;

(l) Access to community resources, including recreation, agency services, employment and alternatives to employment programs, educational opportunities and health care resources;

(m) Transfer of individuals to alternate residences within an RTC;

(n) Individual choice that allows control of their personal affairs;

(o) Appropriate services which promote independence, dignity and self-esteem and are also appropriate to the age and preferences of the individual;

(p) Individual choice to consent to or refuse treatment;

(q) Individual choice to participate in community activities;

(r) Equal pay for equal work; and

(s) Freedom from placing restrictions on an individual's movement by seclusion in a locked room (under any circumstance); restriction to an area of the residence or access to ordinarily accessible areas, unless arranged for and agreed to on the individual's program plan.

(2) Notification of policies and procedures. The RTC shall inform each individual and parent/guardian/advocate orally and in writing of its rights, policy and procedures at time of entry and as changes occur.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0440
Rights: Confidentiality

All individuals' records are confidential except as otherwise indicated by applicable rule or laws.

(1) For the purpose of disclosure from individual medical records under these rules, service providers under these rules shall be considered "providers" as defined in ORS 179.505 shall be applicable.

(2) For the purposes of disclosure from non-medical individual records, both the general exemption applicable to disclosure of "information of a personal nature" and limitations to the prohibition in ORS 192.502(2) shall be applicable.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0450
Rights: Abuse

(1) Policies and procedures. The RTC shall develop and implement policies and procedures governing the reporting, investigation and resolution of allegations of abuse.

(2) Investigation. Allegations of abuse shall be investigated within five working days of receipt of the allegation.

(3) Consequences. Appropriate disciplinary or other action shall be taken on all substantiated cases.

(4) Maintaining documentation. The RTC shall maintain documentation of each abuse allegation and its resolution.

(5) State-Operated Training Centers. State-Operated Training Centers shall be in compliance with OAR 309-116-0000 through 309-116-0025 as they relate to abuse.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0460
Rights: Grievances

(1) Policies and procedures. The RTC shall implement written policies and procedures for individuals' grievances. These policies and procedures shall, at a minimum, provide for:

(a) Receipt of grievances from individual(s) or others acting on his/her behalf;

(b) Investigation of the facts supporting or disproving the grievance;

(c) Appropriate action taken on substantiated cases;

(d) Review of each action by the next higher authority until resolution, to include the RTC Administration and MHDDSD; and

(e) Documentation of each grievance and its resolution in the grievant's record.

(2) Notification of policy and procedures. The RTC shall inform each individual and parent/guardian/advocate orally and in writing of its grievance policy and procedures at time of entry and as changes occur.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0470
Rights: Behavior Intervention

(1) Written policy. The RTC shall have and implement a written policy concerning behavior intervention procedures.

(2) Notification of policy and procedures. The RTC shall inform the individual and parent/guardian/advocate orally and in writing of its behavior intervention policy and procedures at the time of entry and as changes occur.

(3) Implementation of a program to alter an individual's behavior. A decision to implement a program to alter an individual's behavior shall be made by the IDT and the program shall be described fully in the individual's IPP. The program shall:

(a) Emphasize the development of the functional alternative behavior and positive approaches and positive behavior intervention;

(b) Use the least intervention possible;

(c) Assure that abusive or demeaning intervention shall never be used; and

(d) Be evaluated by the RTC through timely review of specific data on the progress and effectiveness of the procedures.

(4) Documentation requirements. Documentation regarding the behavior program shall include:

(a) Documentation that the individual, the guardian, and IDT are fully aware of and consent to the program in accordance with the IPP process;

(b) Documentation of all informal and/or positive; programs used to develop an alternative behavior; and

(c) A written record of a functional analysis of the behavior which is defined as:

(A) A clear, measurable description of the behavior to include frequency, duration, intensity and severity of the behavior;

(B) A clear description of the need to alter the behavior;

(C) An assessment of the meaning of the behavior, which includes the possibility that the behavior is:

(i) An effort to communicate;

(ii) The result of medical conditions;

(iii) The result of environmental causes; or

(iv) The result of other factors.

(d) A description of the conditions which precede the behavior in question;

(e) A description of what reinforces and maintains the behavior; and

(f) A clear and measurable procedure which will be used to alter the behavior and develop the functional alternative behavior.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0480
Rights: Physical Restraints

(1) Circumstances when physical restraint allowed. The RTC shall only employ physical restraint:

(a) As part of an IPP where the restraint is used as a last resort after less restrictive alternatives have been attempted and that is intended to lead to less restrictive means of intervening in and altering the behavior for which the restraint is applied;

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

(c) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for individual protection during the time that a medical condition exists.

(2) Staff training. Staff members who reasonably anticipate needing to apply restraint as part of an individual's on-going training program shall be trained by a Division approved trainer. Documentation verifying such training shall be maintained in his/her training record.

(3) Physical restraints in emergency situations. Physical restraints in emergency situations shall:

(a) Be authorized by the Director/Superintendent or designee, or physician;

(b) Be authorized as soon as individual is restrained or stable; and

(c) Be used only until the individual is calm.

(4) Avoid physical injury. Physical restraint shall be designed to avoid physical injury to the individual and to minimize physical and psychological discomfort.

(5) Documentation. All use of physical restraint shall be documented. The documentation shall include:

(a) The name of the individual to whom the restraint was applied;

(b) The date, type, and length of time of restraint application;

(c) The name and position of the person authorizing the use of the restraint;

(d) The name of the staff member(s) applying the restraint; and

(e) Description of the incident requiring the emergency restraint.

Stat. Auth.: ORS 430.041

Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0490
Psychotropic Medications

(1) Requirements. Medications treating the symptoms of mental illness shall be:

(a) Prescribed by the physician through a written order:

(A) As an emergency measure; or

(B) As an integral part of the individual's program that is directed specifically toward the reduction of and eventual elimination of the symptoms for which the medication has been prescribed.

(b) Recommended by the IDT; and

(c) Approved by guardian or in absence of a guardian, the Director/Superintendent, or their designee. In State Operated Training Centers the approval of the Chief Medical Officer or designee, is also required.

(2) Risk vs. Risk. Drugs used for the control of behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potential harmful effects of the drugs. Documentation shall be available in the individual's record which includes:

(a) A description of the treatment being considered;

(b) A statement documenting review by the IDT of the risks of the treatment versus the risks of not implementing the treatment including less restrictive alternatives; and

(c) Conclusions and rationale of IDT recommendations.

(3) Monitoring and review. Medications for behavior shall be:

(a) Monitored quarterly by the prescribing physician and IDT for desired responses and adverse consequences; and

(b) Gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the IDT, unless clinical evidence justifies that this is contraindicated.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0500
Rights: Handling and Managing Individual's Money

(1) Financial exploitations. The RTC shall ensure that financial exploitation of individuals is prohibited and take appropriate actions to prevent.

(2) Policies and procedures. The RTC shall have and implement written policies and procedures for the handling and management of individuals' money. Such policies and procedures shall provide for:

(a) The individual to manage his/her own funds unless the IPP documents and justifies limitations to self-management;

(b) Safeguarding of an individual's funds;

(c) Individuals receiving and spending money;

(d) Taking into account the individual's interests and preferences.

(3) Individual written record. Individuals shall be encouraged to independently manage their own money. For those individuals not yet capable of managing their own money, as determined by the IDT, the RTC shall be responsible for the accurate preparation and maintenance of an individual written record for each individual of all money received or disbursed on behalf of or by the individual which includes:

(a) The date, amount and source of income received;

(b) The date, amount and purpose of funds disbursed; and

(c) Signature of the staff making each entry.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0510
Rights: Individual's Personal Property

(1) Record of personal property. The RTC shall prepare and maintain an accurate individual written record of each individual's personal property showing:

(a) The description and identifying number, if any;

(b) Date of inclusion in the record;

(c) Date and reason for removal from the record;

(d) Signature of staff making each entry; and

(e) A signed and dated review of the record for accuracy at six month intervals.

(2) Choice. The RTC shall encourage and support individuals having possessions which reflect the interest and choices of the individual.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0520
Entry and Exit

(1) Last resort. Entry into a State-Operated Residential Training Center shall be only considered as a last resort when other less restrictive community options are not available.

(2) Qualifications for RTC services. All individuals considered for RTC services shall:

(a) Be determined to have a developmental disability by the Division or its designee;

(b) Be at least 21 years of age unless an exception is granted by the Assistant Administrator of the DD Office; and

(c) Not be discriminated against because of race, color, creed, handicapping condition, national origin, gender, religion, duration of Oregon residence, method of payment, or other forms of discrimination under applicable state or federal law.

(3) Written information required. Written information shall be provided to the RTC by the person, his/her guardian or the agency requesting the entry prior to the entry meeting. This written information shall include:

(a) Written documentation that the individual has been determined to have a developmental disability;

(b) A statement indicating the individual's safety skills including ability to evacuate from a building when warned by a signal device and adjusting water temperature;

(c) A brief written history of any medical conditions or behavioral challenges;

(d) Documentation from a physician of the individual's current physical condition, including a written record of any current or recommended medications, treatments, diet and aids to physical functioning;

(e) Documentation of the individual's financial resources; and

(f) Documentation of any guardian or conservator, or any other legal restriction on the rights of the individual, if applicable.

(4) Entry meeting. An entry meeting shall be conducted prior to the initiation of services to the individual; the findings of the entry meeting shall be recorded in the individual's file and include at a minimum:

(a) The name of the individual proposed for service;

(b) The date of the meeting;

(c) The date determined to be the date of entry;

(d) Documentation of the participants at the meeting; and

(e) Documentation of the pre-entry information required by subsection (3)(c)–(f) of this rule.

(5) Not optimal placement. In those cases where admission to the RTC is not the optimal service for the individual, but is the most appropriate service available, the inappropriateness shall be documented in the individual's record, and:

(a) Plans shall be implemented for the continued and active exploration of a more appropriate service; and

(b) The entry shall be time-limited to the period of time necessary to secure a more appropriate service.

(6) Assessment of functional skills prior to exit meeting. Each individual considered for exit from an RTC shall have an assessment of his/her functional skills within 30 days prior to the exit unless the individual's annual assessment has been made within 90 days prior to the exit.

(7) Exit meeting. Each individual considered for exit shall have a meeting by the IDT before any decision to exit is made. Findings of such a meeting shall be recorded in the individual's file and include at a minimum:

(a) The name of the individual considered for exit;

(b) The date of the meeting;

(c) Documentation of the participants included in the meeting;

(d) Documentation of the circumstances leading to the proposed exit;

(e) Documentation of the decision regarding exit including verification of a majority agreement of the meeting participants with the decision; and

(f) Documentation of the proposed plan for services for the individual after the exit.

(8) Requirements for waiver of exit meeting. Requirements for an exit meeting may be waived if an individual is immediately removed from the RTC under the following conditions:

(a) The individual and his/her guardian request an immediate exit from the RTC; or

(b) The individual is removed by a legal authority acting pursuant to civil or criminal proceedings; or

(c) The individual is absent without authorization from the RTC for a period exceeding five consecutive days.

(9) Transfer meeting. Transfer of an individual shall be preceded by a meeting of the IOT before any decision to transfer is made. Findings of such a meeting shall be recorded in the individual's file and include, at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the meeting;

(c) Documentation of the participants included in the meeting;

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternatives considered instead of transfer;

(f) Documentation of the reasons any preferences of the individual, legal representative and/or family members cannot be honored;

(g) Documentation of a majority agreement of the participants with the decision; and

(h) The written plan for services to the individual after transfer.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0530
Plan and Assessment

(1) Assessment of individual support needs available. Within 30 days after admission, the IDT must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the individual's age (for example young adult or elderly person) and the implications for active treatment at each stage, as applicable, and must:

(a) Identify the presenting problems and disabilities and where possible, their causes;

(b) Identify the individual's specific developmental strengths;

(c) Identify the individual's developmental and behavior management needs;

(d) Identify the individual's needs for service without regard to the actual availability of the services needed; and

(e) Include:

(A) Affective development;

(B) Speech and language development;

(C) Auditory functioning;

(D) Cognitive development;

(E) Social development;

(F) Adaptive behaviors or independent living skills necessary for the individual to be able to function in the community; and

(G) As applicable, vocational skills.

(2) Individual program plan available. Within 30 days after admission, the IDT must prepare for each individual an "individual program plan" (IPP). The IPP shall:

(a) State specific objectives;

(b) Be implemented as specified; and

(c) Include the collection of relevant and measurable data.

(3) Individual program plan review and revision. The IPP shall be reviewed and revised at a minimum when:

(a) An objective is completed; and/or

(b) The individual is regressing or losing skills; and/or

(c) The individual is failing to progress; and/or

(d) The individual is being considered for training toward a new objective.

(4) Annual review of Individual Program Plan by Inter-Disciplinary Team. The IPP shall include at a minimum an annual review by the IDT.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0540
Individual Furnishings

(1) Bedroom furniture. Bedroom furniture shall be provided, or arranged for each individual and shall include:

(a) A bed, including a frame, and a clean comfortable mattress, waterproof mattress cover if the individual is incontinent and a pillow;

(b) A private dresser or similar storage area for personal belongings which is readily accessible to the individual; and

(c) A closet or similar storage area for clothing which is readily accessible to the individual.

(2) Linens. No less than two sets of linens shall be provided, or arranged, for each individual and shall include:

(a) Sheets and pillowcases;

(b) Blankets, appropriate in number and type for the season and the individual's comfort; and

(c) Towels and washcloths.

(3) Personal hygiene equipment and supplies. Each individual shall have his/her own personal hygiene equipment and supplies which shall be stored in a sanitary manner.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0550
Program Management

(1) Non-discrimination. The RTC shall comply with all applicable state and federal statutes in regard to non-discrimination in employment practices.

(2) No retaliation. The RTC shall have a policy prohibiting discrimination or retaliation against an employee or individual who makes a good faith abuse report to state authorities or participates in an abuse investigation or proceeding.

(3) Documentation requirements. All entries required by this rule unless stated otherwise, shall:

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

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

(c) Be maintained for no less than three years.

(4) Dissolution of RTC. Prior to the dissolution of an RTC, a representative of the RTC shall notify the Division 30 days in advance in writing and make appropriate arrangements for the transfer of individual's records.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0560
Civil Penalties

(1) Long-term care facility statute applicable. For purposes of imposing civil penalties, RTCs licensed under ORS 443.440 to 443.455 and subsection (2) of ORS 443.991 are considered to be long-term care facilities subject to ORS 441.705 through 441.745.

(2) Sections of rule subject to civil penalties. Violations of any requirement within any part of the following sections of the rule may result in a civil penalty up to $500 per day for each violation not to exceed $6,000 for all violations for any licensed RTC within a 90 day period: OAR 309-043-0310(3)(5); 309-043-0320; 309-043-0330; 309-043-0340; 309-043-0350; 309-043-0360; 309-043-0380; 309-043-0390; 309-043-0400; 309-043-0410; 309-043-0420; 309-043-0430, 309-043-0440, 309-043-0450, 309-043-0460, 309-043-0470, 309-043-0480, 309-043-0490; 309-043-0540(1) and (2); and 309-043-0550(2).

(3) Penalty imposed for other rule violations. Civil penalties of up to $300 per day per violation may be imposed for violations of any section of this rule not listed in section (2) of this rule if a violation has been cited on two consecutive inspections or surveys of an RTC where such surveys are conducted by an employee of the Division. Penalties assessed under this section shall not exceed $6,000 within a 90 day period.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0570
License Denial, Suspension, Revocation

(1) Conditions. A license may be denied or revoked by the Division when it finds the applicant, or any person holding five percent or greater financial interest in the applicant:

(a) Demonstrates substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized and

fails to correct the non-compliance within 30 calendar days of such finding; or

(b) Has demonstrated a substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized during three inspections within a six-month period (for the purpose of this subsection, "inspection" means an on-site visit to the RTC by the Division for the purpose of investigation or licensing); or

(c) Has demonstrated a failure to comply with applicable laws relating to safety from fire; or

(d) Has been convicted of a felony; or

(e) Has been convicted of a misdemeanor associated with the operation of an RTC; or

(f) Falsifies information required by the Division regarding care of individuals, RTC finances or individuals' funds; or

(g) Has been found to have permitted, aided or abetted any illegal act which has had significant adverse impact on individual health, safety or welfare.

(2) Immediate suspension or license denial. In any case where the Division finds an imminent danger to the health and safety of the residents and sets forth the specific reasons for such findings, the Division may suspend or refuse to renew a license without a pre-termination or pre-suspension hearing, and the RTC may not continue operation.

(3) Notice of intent to revoke or deny license. Following a Division finding that there is a substantial failure to comply with these rules such that the health, safety or welfare of individuals is jeopardized, or any other reason listed in section (1) of this rule, the Division may issue a notice of intent to revoke or deny license.

(4) Informal conference. Following the notice issued pursuant to section (3) of this rule, the Division shall provide the licensee an opportunity for an informal conference within ten calendar days from the date of the notice.

(5) Hearing. Following issuance of a notice of intent to revoke or deny license, the Division shall provide the opportunity for a hearing pursuant to OAR 309-043-0580.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

309-043-0580
Hearings

(1) Request for hearing. Upon written notification by the Division of intent to revoke or deny a license, pursuant to OAR 309-043-0570(1), the licensee shall be entitled to a hearing in accordance with ORS Chapter 183 if a hearing is requested in writing within 60 days from the written notification. The request for hearing shall include an admission or denial of each factual matter alleged by the Division and shall affirmatively allege a short plain statement of each relevant affirmative defense the licensee may have.

(2) Hearing rights under OAR 309-043-0570(2). The immediate suspension or denial of a license under OAR 309-043-0570(2) is made pending a fair hearing not later than the tenth day after such suspension or denial.

(3) Issue at hearing after immediate suspension or denial pursuant to OAR 309-043-0570(1)(a). The issue at the fair hearing on immediate license denial or suspension pursuant to OAR 309-043-0570(1)(a) is limited to whether there was an imminent danger to the health and safety of the residents. Further hearing rights are controlled by ORS 183.430(2).

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 1-1994, f. & cert. ef. 1-27-94

PROGRAMS FOR DEVELOPMENTAL DISABILITIES

DIVISION 45

NOTICE AND REVIEW OF SUBSTANTIATED ABUSE OR NEGLECT IN 24-HOUR RESIDENTIAL CARE FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

309-045-0100 [Renumbered to **407-045-0600**]

309-045-0110 [Renumbered to **407-045-0610**]

309-045-0120 [Renumbered to **407-045-0620**]

309-045-0130 [Renumbered to **407-045-0630**]

309-045-0140 [Renumbered to **407-045-0640**]

309-045-0150 [Renumbered to **407-045-0650**]

309-045-0160 [Renumbered to **407-045-0660**]

309-045-0170 [Renumbered to **407-045-0670**]

309-045-0180 [Renumbered to **407-045-0680**]

309-045-0190 [Renumbered to **407-045-0690**]

309-045-0200 [Renumbered to **407-045-0700**]

309-045-0210 [Renumbered to **407-045-0710**]

DIVISION 48

INTERMEDIATE AND SKILLED NURSING FACILITIES

PASARR — Pre-Admission Screening and Annual Resident Review

309-048-0050
Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe Mental Health and Developmental Disability Services Division standards and procedures regarding the screening, evaluation and provision of specialized services to persons with mental illness who apply for or reside in Medicaid certified nursing facilities. They implement Public Law 100-203 of the Omnibus Budget Reconciliation Act of 1987 that added Section 1919 to the Social Security Act.

(2) Statutory authority and procedure. These rules are authorized by ORS 430.041 and to carry out the provisions of Public Law 100-203.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0060
Definitions

As used in these rules:

(1) "Annual resident review" means the review of referrals from the annual resident screening process by designees of the Mental Health and Developmental Disability Services Division. The purpose of the review is to determine the need for a Level II psychiatric evaluation.

(2) "Annual resident screening" means the annual screening by nursing facility staff of all residents for acute symptoms or indicators of mental illness.

(3) "Categorical determination" means a decision made by a contractor of the Senior and Disabled Services Division based on a functional assessment. This determination identifies a person who, despite the presence of mental illness, can be admitted to a nursing facility. The categories are:

(a) Individuals requiring nursing facility care for 30 days or less for convalescent care following an acute care hospitalization for illness or surgery;

(b) Persons with terminal illness with a prognosis of six months or less; and

(c) Persons with severe medical condition that precludes participation in or benefit from specialized services.

(4) "Client Process Monitoring System (CPMS)" means the automated client data system maintained by the Mental Health and Developmental Disability Services Division.

(5) "Community Mental Health Program (CMHP)" means the organization of all services for persons experiencing problems related to mental illness, drug and alcohol abuse, and mental retardation or other developmental disabilities, operated by, or contractually affiliated with, a local mental health authority operated in a specific geographic

area of the state under an intergovernmental agreement or direct contract with the Division.

(6) "Determination" means the decision/recommendation made by a designee of the Division regarding an individual's eligibility for Level II evaluation, i.e., presence of a serious mental illness and need for "specialized services" as required by Public Law 100-203. Determinations regarding an individual's need for nursing facility services are the responsibility of the Senior and Disabled Services Division.

(7) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services of the State of Oregon.

(8) "Indicators of mental illness — applicants." Applicants to nursing facilities with a diagnosis of a major mental disorder and a history of treatment related to his diagnosis in the past two years are considered to have indicators of mental illness. Alzheimer's and/or a diagnoses of dementia are excluded from this definition of major mental disorder.

(9) "Indicators of mental illness — residents." Residents of nursing facilities with psychiatric or behavioral symptoms that indicate a need for "specialized services" are considered to have indicators of mental illness regardless of diagnosis or history of treatment.

(10) "Level I" means the federally required screening for indicators of mental illness process implemented by the Senior and Disabled Services Division under OAR 411-070-0043. All applicants to nursing facilities are screened for indicators of mental illness and a determination made whether the applicant requires nursing facility care based on a functional assessment.

(11) "Level II" means the evaluation process conducted by designees of the Division to determine whether an individual with mental illness requires specialized services. The determination is based on a current functional assessment, history and physical, psychosocial evaluation, a mental health assessment and a medication review.

(12) "Level II summary" means the form approved by OMHS which identifies data to be collected by Division designees in the Level II evaluation.

(13) "Licensed medical professional" means a medically trained person who is licensed to practice in the State of Oregon and has one of the following degrees: MD (Medical Doctor); DO (Doctor of Osteopathy); NP (Nurse Practitioner); PA (Physician's Assistant); or RN (Registered Nurse).

(14) "Nursing facility (NF)" means a facility that contains Medicaid certified inpatient beds and provides medical services but excludes hospital/surgical procedures. The facility must be licensed and certified by the Senior and Disabled Services Division under ORS 410.060 and 441.025.

(15) "Office of Mental Health Services (OMHS)" means that portion of the Division responsible for mental health services.

(16) "Pre-admission screening (PAS)" is the state required process used by the Senior and Disabled Services Division to screen all Medicaid eligible persons seeking admission to nursing facilities. This screening covers functional, medical, economic and psychosocial variables and is the basis for making a determination regarding the individual's categorical status and his/her need for nursing facility services.

(17) "Pre-Admission Screening and Annual Resident Review (PASARR)" is the assessment process conducted by agencies within the Department of Human Services that implements the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), Subsection 1919(e)(7), which prohibits a Medicaid certified nursing facility from admitting any individual until a screening is completed to determine mental illness or mental retardation (or related conditions), and whether the individual requires nursing facility services or specialized services for mental illness.

(18) "Private admission assessment" is the process that SDSD uses to screen for indicators of mental illness and categorical status in non-Medicaid applicants to nursing facilities.

(19) "Qualified mental health professional (QMHP)" means a mental health practitioner with qualifications defined in OAR 309-032-0535(26), Standards for Adult Mental Health Services.

(20) "Senior and Disabled Services Division (SDSD)" means the Department of Human Services agency responsible for the provision of nursing facility services as specified in OAR chapter 411.

(21) "Specialized psychiatric rehabilitative services" means services of a lesser intensity than required under specialized services for mental illness. The nursing facility may provide these services directly or make arrangements for their provision with private sector practitioners or community mental health programs.

(22) "Specialized services for mental illness" means the implementation of an individualized plan of care developed, provided and supervised by a physician and qualified mental health professionals in an inpatient psychiatric hospital. This plan of care shall prescribe specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness. A nursing facility resident requiring specialized services shall be considered to be eligible for the level of services provided in an inpatient psychiatric hospital. Residents requiring this level of care will require relocation to an inpatient facility until the "acute" nature of their symptoms are stabilized.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0070
Procedures for Level I, Pre-Admission Screening (PAS)

(1) Nursing facility placement. A person identified with mental illness indicators who requests placement in a nursing facility must meet SDSD-PAS criteria demonstrating a need for nursing facility care. The person may be placed in a nursing facility without a Level II evaluation if the person:

(a) Meets criteria of categorical determinations OAR 309-048-0060(3); or

(b) Has a primary diagnosis of dementia; and

(c) Does not require specialized services OAR 309-048-0060(22).

(2) Level II referrals. Persons shall be referred to the Office of Mental Health Services for a Level II evaluation prior to placement in a nursing facility if:

(a) A Level I pre-admission screen or a private admission assessment has identified the individual as having indicators of mental illness; and

(b) The individual is *not* eligible for a categorical determination.

(3) Level II waiver. The OMHS may waive the Level II evaluation requirement if:

(a) The individual does not need specialized services or has received maximum benefit from specialized services; and

(b) The individual has been determined to be in need of nursing facility services by an SDSD designee or contractor; and

(c) A facility has been identified that can meet the individual's mental health needs.

(4) Level II eligibility. Individuals may be required by OMHS to have a Level II evaluation to determine the need for specialized services prior to placement in a nursing facility if any of the above conditions (subsections (3)(a), (b) and (c) of this rule) are not met.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0080
Procedures for Annual Resident Reviews (ARR)

A resident screened and referred by a nursing facility as having indicators of mental illness shall be reviewed by an OMHS designee using a format approved by the Division.

(1) Timelines. The review shall be completed by a QMHP within 7 working days of receipt of the referral from the nursing facility.

(2) Screening and consultation. The review shall consist of up to two hours of screening and consultation to determine if the indicators of mental illness require a comprehensive evaluation (Level II).

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0090
Level II Evaluations

(1) Content. A Level II evaluation shall:

(a) Be completed by a QMHP within 30 calendar days of the annual resident review referral or within seven working days of the pre-admission screening referral;

(b) Include a mental health assessment, a psychosocial evaluation, relevant testing and a review of the medication regime and physical examination by a licensed medical professional;

(c) Establish a diagnosis and determine the need for specialized services.

(2) Specialized psychiatric rehabilitation. If the need for specialized services is not established, the evaluation shall include treatment recommendations for specialized psychiatric rehabilitation services whenever indicated.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0100
Documentation

(1) Level II waivers. The OMHS shall send a copy of any waiver from the pre-admission requirement for a Level II, to the SDSD Level I screener who has determined that the individual needs nursing facility care pursuant to OAR 309-048-0060(11).

(2) Nursing facility. CMHP evaluators shall send copies of the annual resident review and Level II evaluation to the nursing facility within 7 and 30 days respectively.

(3) Office of Mental Health Services. CMHP evaluators shall send copies of the annual resident review, Level II evaluation and the Level II summary sheet to the OMHS within 30 days of receipt of the nursing facility referral.

(4) Client Process Monitoring System. CMHP designees shall enter information on all persons receiving a Level II evaluation into CPMS.

(5) Standards. Level II evaluations shall follow documentation standards set forth in OAR 309-032-0575(3), Standards for Adult Mental Health Services.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0110
Specialized Services for Individuals Residing in Nursing Facilities

(1) Location. Specialized services for persons with mental illness are provided only in inpatient psychiatric settings that provide 24 hour coverage by trained mental health professionals who can deliver mental health services designed by an interdisciplinary team which includes a psychiatrist.

(2) Readmission to nursing facilities. A person identified by a Level II evaluation as in need of specialized services shall not enter or remain in a nursing facility. When a client has received maximum benefit from specialized services, the client can be reconsidered for admission subject to Level I requirements or return to a nursing facility placement subject to SDSD OAR 411-088-0000 to 411-088-0080, Licensing Requirements for Nursing Facilities, Transfer Rules.

(3) Procurement of specialized services. When a client is identified to be in need of specialized services, the Level II evaluator shall:

(a) Assist the nursing facility or Level I screener in locating an appropriate treatment resource;

(b) Insure that the client in need of specialized services is informed of his/her treatment options including the right to refuse treatment;

(c) Inform all parties involved, of procedures related to precommitment investigation, if the client refuses specialized services and presents a danger to self or others;

(d) Notify the OMHS within 72 hours if a client is determined to be in need of specialized services and these services are not being provided.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0120
Relocation of Persons with Mental Illness From Nursing Facilities to Other Residential Settings

(1) Coordination of Plans. CMHP, NF and SDSD staff shall coordinate relocation plans for residents of nursing facilities with mental illness found to be ineligible for nursing facility care.

(2) Right of return. All relocations of residents must comply with nursing facility transfer rules, division 88, OAR 411.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

309-048-0130
Appeals

In accordance with ORS 430.041, adults with mental illness, and court approved legal guardians for individuals with mental illness, shall have the right to appeal decisions made by the Division based on screenings, admission waiver request, discharge and relocation plans.

(1) Appeals. Appeals shall be submitted to the Adult and Family Services Division (AFSD) Hearings Office and arrive there within 30 calendar days after receipt of the contested determination/decision.

(2) Negotiations. The Adult and Family Services Division Hearings Office shall, when it deems appropriate, refer appealed decisions back to the Division for efforts to negotiate an agreement. If the Division is unable to negotiate an agreement within 10 working days, the Division will remand the appeal back to the AFSD Hearings Office for final disposition.

(3) Hearings. The AFSD Hearings Office shall convene a hearing in accordance with OAR 461-025-0305 through 461-025-0385, and reach a final determination on the appeal within ninety (90) days of the final day of the hearing.

(4) Determinations. All decisions of the AFSD Hearing Office shall be final.

Stat. Auth.: ORS 430.041
Stats. Implemented:
Hist.: MHD 2-1995, f. & cert. ef. 4-6-95

DIVISION 49

RESIDENTIAL PROGRAMS

309-049-0000
Purpose and Statutory Authority

(1) Purpose. These rules require providers of residential services to persons under 21 years of age with developmental disabilities to notify the public school system prior to establishing, expanding, or changing the program.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and carry out the provisions of ORS 339.175.

Stat. Auth.: ORS 339 & 430
Stats. Implemented:
Hist.: MHD 1-1987, f. & ef. 1-12-87

309-049-0005
Definitions

(1) "Developmental Disability (DD)" means a person with a disability which is attributed to mental retardation, cerebral palsy, epilepsy or other neurological handicapping condition which requires training similar to that required by persons with mental retardation. Characteristics of the developmental disability are that it:

(a) Originates before the person attains the age of 22 years, except that in case of mental retardation the condition must be manifested before the age of 18;

(b) Has continued, or can be expected to continue indefinitely;

(c) Constitutes a substantial handicap to the person's ability to function in society; and

(d) In the case of mental retardation, means a person with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Persons of borderline intelligence may be considered to have mental retardation if there is also serious impairment of adaptive behavior. Definitions and classifications shall be consistent with the **"Manual on Terminology and Classification in Mental Retardation" of the American Association on Mental Deficiency, 1977 Revision**. Mental retardation is synonymous with mental deficiency. For community case management purposes, mental retardation includes those persons of borderline intelligence who have a history of residence in a state training center:

(A) "Adaptive Behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected for age and cultural group;

(B) "Developmental Period" means the period of time between birth and the 18th birthday;

(C) "Intellectual Functioning" means functioning as assessed by one or more of the individually administered general intelligence tests developed for that purpose;

(D) "Significantly Subaverage" means a score on a test of intellectual functioning that is two or more standard deviations below the mean for the test.

(2) "Disability Characteristics" means handicapping conditions such as mental retardation, seizures, motor dysfunction, cerebral palsy, behavior problems, communication disorders, visual and auditory dysfunction and other health impairments.

(3) "DD Residential Program" means DD residential homes and DD small residential homes serving residents with developmental disabilities who are under the age of 21. This rule does not apply to DD foster homes.

(4) "Resident" means a person served by and residing in a DD residential program.

(5) "Superintendent" means the highest ranking administrative officer in a school district or an educational institution, or in the absence of the superintendent, the person designated to fulfill the functions.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 339 & 430
Stats. Implemented:
Hist.: MHD 1-1987, f. & ef. 1-12-87

309-049-0010
Notice and Consultation With School Districts

The Administrator or Board of Directors of any DD residential program intending to establish or expand services to persons under the age of 21, or intending to change the category of residents being served, shall provide written notification to the superintendent of any affected local school district. To assist local school districts in planning special education services for additional or different students with developmental disabilities, the written notification shall include information about the characteristics and needs of residents including but not limited to:

(1) Age ranges;

(2) Abilities to ambulate; and

(3) Expectations of residents' disability characteristics.

Stat. Auth.: ORS 339 & 430
Stats. Implemented:
Hist.: MHD 1-1987, f. & ef. 1-12-87

309-049-0015
Three-Month Notification Requirement

(1) The written notification required by this rule shall occur not less than three months prior to events described in OAR 309-049-0010.

(2) The three-month period, or any part of it, may be waived by agreement of the DD residential program and the affected school district.

(3) Copies of the written notification shall be forwarded to the Director of the Community Mental Health Program, the Associate Superintendent of Special Education at the Oregon Department of Education, and to the Assistant Administrator of the Oregon Mental Health and Developmental Disability Services Division for DD Programs.

Stat. Auth.: ORS 339 & 430
Stats. Implemented:
Hist.: MHD 1-1987, f. & ef. 1-12-87

309-049-0020
Exclusion

This rule does not apply to changes in, or expansion of, DD residential programs for less than 30 days duration.

Stat. Auth.: ORS 339 & 430
Stats. Implemented:
Hist.: MHD 1-1987, f. & ef. 1-12-87

DIVISION 100

PATIENT AND RESIDENT RIGHTS

309-100-0000
Nondiscrimination

(1) Purpose. This rule prescribes nondiscriminatory admission requirements for all facilities of the Mental Health and Developmental Disability Services Division and community mental health programs.

(2) Statutory Authority and Procedure. This rule carries out and is authorized by ORS 179.040, 179.321, 179.360, ORS Chapters 426 and 427, and ORS 430.620.

(3) Admission Requirements. No Division facility or community mental health program shall discriminate on the grounds of race, religion, ethnic group, age, or sex against any person seeking admission. However, an admission may be denied or delayed if an appropriate facility placement is not available because of age or sex, or combination thereof, of the person seeking admission.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 22, f. 8-5-74, ef. 8-25-74; Renumbered from 309-021-0000

DIVISION 102

HANDLING OF MAIL OF PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-102-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures for the handling of incoming and outgoing mail of patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 179.321, 426.385, 426.395, and 427.031.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 17-1980(Temp), f. & ef. 6-30-80; MHD 19-1980, f. & ef. 12-10-80; MHD 27-1982, f. 12-28-82, ef. 1-28-83, Renumbered from 309-021-0030(1) and (2)

309-102-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Legal Mail" means any mail from, or addressed to, any attorney, any court, and any legal aid bureau or service.

(4) "Mail" means sealed envelopes and parcels.

(5) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(6) "Prohibited Item" means:

(a) Alcoholic beverages, controlled substances, and prescription and non-prescription drugs or medications;

(b) Any item that reasonably can be used as a weapon or instrument of escape;

(c) Any item the possession of which is detrimental to the treatment and training or health and safety of the patients or residents in a particular ward or cottage and which is prohibited in writing and posted on the affected ward or cottage; and

(d) Any item the possession of which is detrimental to the treatment and training of an individual patient or resident and which is recorded in the treatment and training orders section of the patient's or resident's chart by the treating physician or qualified mental retardation professional.

(7) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401** or as amended.

(8) "Reasonable Cause" means that the person has knowledge or notice of facts and circumstances which would lead a person of ordinary care and prudence to have a strong suspicion.

(9) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(10) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(11) "Superintendent" means the executive head of the state institution as listed in section (10) of this rule.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 17-1980(Temp), f. & ef. 6-30-80; MHD 19-1980, f. & ef. 12-10-80; MHD 27-1982, f. 12-28-82, ef. 1-28-83, Renumbered from 309-021-0030(3)

309-102-0010
Policy

(1) All patients and residents in state institutions shall have the right to communicate freely in person by sending and receiving sealed mail.

(2) Except as provided in section (3) of this rule, no employee or any person acting through, or on the behalf of, the Division shall:

(a) Open, read, censor, inspect, or otherwise examine any patient's or resident's incoming or outgoing mail without the expressed permission of the patient or resident who is the sender or the receiver of the mail. Patients and residents are responsible for any items received by them by mail, and should request staff to record any property received on the personal property record;

(b) Prevent, obstruct, or delay any patient's or resident's outgoing mail from being promptly mailed;

(c) Prevent, obstruct, or delay any patient's or resident's incoming mail from being delivered or forwarded promptly to the patient or resident.

(3)(a) Unless the patient or resident objects, an employee may provide assistance in reading or sending mail for those patients or residents who have physical or mental handicapping conditions which interfere with the ability to use the mail. Need for this assistance shall be documented in the patient's or resident's chart by the physician or qualified mental retardation professional;

(b) When there is reasonable cause to suspect that mail contains a prohibited item, the procedure described in OAR 309-102-0015 shall be followed;

(c) When there is reasonable cause to suspect that incoming or outgoing mail contains evidence of a crime or potential crime, the superintendent, or the superintendent's designee, may hold mail for a reasonable period of time while a search warrant is being sought.

(4) Patients and residents shall be provided with a reasonable amount of writing material by the state institution. Stamps shall be available for purchase by the patient or resident at each state institution.

(5) The designation of an item as prohibited, the proposed disposition of the item, any interference with the delivery of incoming or outgoing mail, or any other application of these rules may be contested in accordance with OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(6) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division shall constitute cause for disciplinary action.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 17-1980(Temp), f. & ef. 6-30-80; MHD 19-1980, f. & ef. 12-10-80; MHD 27-1982, f. 12-28-82, ef. 1-28-83, Renumbered from 309-021-0030(4)

309-102-0015
Procedures

When there is reasonable cause to suspect that mail contains a prohibited item, the procedure for inspecting mail set forth below shall be followed:

(1) The superintendent of the state institution, or his designee, may require the patient or resident to open the mail in the presence of an employee of the state institution or require an employee to open the mail in the presence of the patient or resident.

(2) A prohibited item found in incoming mail shall be removed and placed in an envelope or other suitable container that shall be clearly marked to identify at least the following:

(a) The date of inspection and confiscation;

(b) The name of the patient or resident to whom the mail was addressed;

(c) The name and address of the sender;

(d) A list and description of the item(s) confiscated; and

(e) The signature of the employee conducting the inspection and authorizing the confiscation.

(3) Copies of the signed list shall serve as a receipt. One copy shall be placed in the patient's or resident's record, one copy shall remain with the item(s), and one copy shall be given to the patient or resident.

(4) The original envelope or other container of mail which has been inspected for prohibited items or from which a prohibited item has been removed shall be marked to correspond exactly with the identification required by section (2) of this rule.

(5) Nonprohibited items shall not be read or otherwise subjected to further inspection and shall be delivered immediately to the patient or resident.

(6) Items confiscated from incoming mail shall be handled as provided in rules established by the Division for the handling of personal property of patients and residents in state institutions.

(7) The manner of disposition of a prohibited item shall be in writing and kept as a record by the state institution.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 17-1980(Temp), f. & ef. 6-30-80; MHD 19-1980, f. & ef. 12-10-80; MHD 27-1982, f. 12-28-82, ef. 1-28-83, Renumbered from 309-021-0030(4)

309-102-0020
Special Exception

From time to time, the Administrator may designate certain areas of the state institutions as locked high security areas. The superintendent of the state institutions shall request in writing such designation by ward or cottage. The Administrator shall approve or disapprove the designation within 30 days of the request. In such areas, employees of the state institutions are authorized to open all mail in the presence of the patient or resident except legal mail as prescribed in OAR 309-102-0015, even though there may not be reasonable cause to believe that a specific piece of mail contains a prohibited item.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 17-1980(Temp), f. & ef. 6-30-80; MHD 19-1980, f. & ef. 12-10-80; MHD 27-1982, f. 12-28-82, ef. 1-28-83, Renumbered from 309-021-0030(5)

309-102-0025
Notice to Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 17-1980(Temp), f. & ef. 6-30-80; MHD 19-1980, f. & ef. 12-10-80; MHD 27-1982, f. 12-28-82, ef. 1-28-83, Renumbered from 309-021-0030(4)

DIVISION 104

TELEPHONE USE BY PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-104-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe policy and procedures for the use of telephones by patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 426.385 and 427.031.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(4) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401** or as amended.

(5) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(6) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(7) "Superintendent" means the executive head of a state institution listed in section (6) of this rule.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0010
Policy

(1) All patients and residents have the right to make and receive telephone calls except as provided in section (4) of this rule.

(2) State institutions shall make available to patients and residents telephones which are accessible and ensure privacy.

(3) Except as stated in section (4) of this rule, no employee or any person acting through, or on behalf of, the Division shall monitor telephone conversations, or prevent or obstruct a patient or resident from making or receiving telephone calls.

(4) State institutions shall have the right to restrict use of telephones under the following circumstances:

(a) State institutions may set reasonable hours for telephone use by patients and residents for both incoming and outgoing calls. Exceptions to this provision are a patient's or resident's lawyer, clergy or personal physician, or in emergency situations;

(b) Unless the patient or resident objects, an employee may provide assistance in making or receiving telephone calls for those residents or patients who have physical or mental handicapping conditions which prevent them from performing these activities. Need for this assistance must be documented in the patient's or resident's chart by a physician or qualified mental retardation professional;

(c) State institutions have the right to reasonably restrict telephone usage if a patient or resident misuses or abuses access to telephones.

(5) Access to telephones shall not be denied in connection with any behavioral contingencies or earned privileges.

(6) State institutions may install public telephones on living units for patients and residents as long as the institution ensures that telephones are private, available, and accessible. Calls to a patient's or resident's attorney, private physician, or clergyman will not be restricted solely on account of funds.

(7) A patient or resident has the right to contest any restriction on access to telephones or other application of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(8) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0015
Procedures

(1) State institutions shall make known telephone availability and any restrictions to patients and residents on each living area.

(2)(a) Any restrictions in telephone usage for individual patients or residents must be by order of the treating physician or qualified mental retardation professional;

(b) Decisions by the physician or qualified mental retardation professional to restrict telephone usage must be documented in the patient's or resident's record by that professional. Specific reasons for the restriction must be clearly stated with supporting documentation as needed.

(3) State institutions must notify, in writing, the affected patient or resident of restrictions within 24 hours after imposing a restriction. The notification must state the reasons and duration of the restriction. There must be at least an oral explanation of the patient's or resident's right to appeal the restriction through the Division's grievance procedures.

(4) Decisions to restrict telephone usage must be reviewed and, if necessary, renewed at least monthly by the physician or qualified mental retardation professional. Restrictions will expire unless renewed.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

309-104-0020
Notice To Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 28-1982, f. 12-28-82, ef. 1-28-83

DIVISION 106

VISITATION OF PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-106-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe policy and procedures concerning visitation of patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 426.385 and 427.031.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(4) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401** or as amended.

(5) "Reasonable Cause" means that the person must have knowledge or notice of facts and circumstances which would lead a person of ordinary care and prudence to have a strong suspicion.

(6) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(7) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(8) "Superintendent" means the executive head of the state institution as listed in section (7) of this rule.

(9) "Visitor" means any person who is not a patient or resident of a particular ward or cottage and is not a Division employee or volunteer regularly assigned to the state institution.

[Publication: Publications referenced are available from the agency.]
Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0010
Policy

(1) The Division recognizes the needs of patients and residents to have access to and maintain contact with family members and the community of which they are a part as well as the needs of family and community members to have access to patients and residents. Except as provided in section (6) of this rule, patients and residents have the right to receive visits from anyone they wish.

(2) State institutions shall provide designated places for visitations to occur in as much comfort and privacy as possible.

(3) State institutions may set reasonable limitations on visitation hours.

(4) State institutions shall post visitation rules and restrictions on every living unit and in the administration area.

(5) A patient's or resident's lawyer, physician or clergy shall not be restricted to the time and place limitations established by the institution under sections (2) and (3) of this rule.

(6) State institutions shall have the right to restrict visitation under the following circumstances:

(a) The patient or resident refuses to see the visitor;

(b) Reasonable cause exists to believe that the visitor would be harmful to the patient's or resident's physical or mental health;

(c) The visitor's behavior is unreasonably disruptive to the institution or any part thereof;

(d) Reasonable cause exists to believe that the visitor would endanger the safety of patients, residents or staff by introducing contraband or assisting in planning or executing escape from the institution;

(e) The visit would constitute an unreasonable intrusion into the privacy of one or more residents or patients;

(f) Alcohol and drug programs in state institutions may impose a programmatic restriction on visitation of up to two weeks for newly admitted patients. Exceptions to this restriction are the patient's lawyer, clergy, and private physician;

(g)(A) The patient or resident has been adjudicated incompetent and has a legal guardian, or the patient or resident is an unemancipated minor;

(B) The legal guardian or custodial parent of the patient or resident has requested a restriction and has demonstrated good cause therefor; and

(C) The treating physician or qualified mental retardation professional has ordered the restriction pursuant to the request of the legal guardian or custodial parent.

(7) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0015
Procedures

(1) Each institution shall designate a central location to initially receive visitors and shall make available information on visitation procedures and restrictions.

(2) Decisions by the physician or qualified mental retardation professional to restrict a visitor must be documented in the patient's or resident's record by that professional. Specific reasons for the restriction must be clearly stated with supporting documentation, as needed.

(3) State institutions must notify the affected patient or resident of a restriction in writing and within 24 hours of imposing the restriction. The notification must state the reasons and duration of restriction and explain to the patient or resident the right to appeal imposition of the restriction.

(4) Decisions to restrict a visitor must be reviewed and, if necessary, renewed at least monthly for a patient and at least quarterly for a resident by the physician or qualified mental retardation professional. Restrictions will expire unless renewed.

(5) A patient, resident, parent, guardian, or other persons significantly involved with a patient or resident has the right to contest any restriction on visitors or other application of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

309-106-0020
Notice to Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 29-1982, f. 12-28-82, ef. 1-28-83

DIVISION 108

HANDLING OF PERSONAL PROPERTY OF PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-108-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe procedures for the handling of personal property of patients and residents in state institutions.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 426.385 and 427.031.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(4) "Prohibited Item" means:

(a) Alcoholic beverages, controlled substances, and prescription and non-prescription drugs or medications;

(b) Any item that reasonably can be used as a weapon or instrument of escape;

(c) Any item the possession of which is detrimental to the treatment and training or health and safety of the patients or residents in a particular ward or cottage and which is prohibited in writing and posted on the affected ward or cottage; and

(d) Any item the possession of which is detrimental to the treatment and training of an individual patient or resident and which is recorded in the treatment and training orders section of the patient's or resident's chart by the treating physician or qualified mental retardation professional.

(5) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401** or as amended.

(6) "Reasonable Cause" means that the person has knowledge or notice of facts and circumstances which would lead a person of ordinary care and prudence to have a strong suspicion.

(7) "Search" means a close inspection of a patient/resident's person, and a patient/resident's room or living area and personal property whenever there is a reasonable cause that said patient/resident may be in possession of a prohibited item.

(8) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(9) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

(10) "Superintendent" means the executive head of the state institution as listed in section (8) of this rule.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0010
Policy

(1) All patients and residents shall have the right to retain and use on each ward or cottage reasonable amounts of personal property, other than prohibited items. State institutions shall provide on each ward or cottage private, adequate, and accessible storage for reasonable amounts of personal property:

(a) Patients and residents needing specific assistance in exercising the right to retain and use personal property shall receive such assistance. This shall be documented in the treatment or training plan;

(b) Each state institution shall develop procedures to protect the personal property of patients and residents against theft by other patients and residents.

(2) State institutions shall designate one or more locations for storage of reasonable amounts of excess personal property. Excess personal property is property which cannot be stored on the patient's or resident's ward or cottage due to size or amount.

(3) State institutions shall provide a secure location for storage of patients' and residents' valuables. Valuables include, but are not limited to, stocks, bonds, jewelry, cash above the amount permitted on the ward or cottage, heirlooms, credit cards, driver's license and any other small item, excluding prohibited items and excess property, which a patient or resident wants retained in a secure location.

(4) Excess property and valuables shall be returned to the patient or resident upon release or discharge of the patient or resident, or upon request of the patient or resident if there is space available on the ward or cottage to accommodate it.

(5) Prohibited items shall be handled as provided in OAR 309-108-0015(6).

(6) State institutions may restrict the amount of cash allowed to be retained by patients or residents on the living unit.

(7) A patient/resident may be searched by Division personnel whenever said personnel have reasonable cause to believe that a patient/resident may be in possession of a prohibited item.

(8) No employee or any person acting through, or on behalf of the Division shall censor a patient's or resident's personal property unless there is reasonable cause to believe that such item is contrary to the treatment and training goals of the individual. Such censorship must be documented in the patient's or resident's record by the treating physician or qualified mental retardation professional with supporting documentation, as necessary and communicated to the patient or resident in writing.

(9) Patients and residents shall have the right to appeal the application of any portion of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(10) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0015
Procedures

(1) All personal property that a patient or resident brings into the institution at the time of admission must be itemized in writing with an accompanying description, regardless of where the item is stored.

(2) Staff shall encourage and assist patients and residents to mark all personal property in such a way which identifies it as an individual patient's or resident's possession.

(3) Any medications brought by the patient or resident at the time of admission should be sent home with a legal guardian or family member if possible. If this is not possible, the medication must be marked with the patient's or resident's name and case number and sent to the pharmacy of the state institution until the patient or resident is discharged.

(4) Patients and residents may bring, or have brought or sent in, nutritional supplements (e.g., vitamins and minerals), and may use them provided that the patient's or resident's treating physician inspects, tests, or otherwise checks the substance claimed to be a nutritional supplement and determines that:

(a) The substance is a nutritional supplement;

(b) The substance is safe for human consumption or use; and

(c) Use or consumption of the nutritional supplement will not interfere with the testing, diagnosis, treatment, or training of the patient or resident; and

(d) The nutritional supplements are kept by the ward or cottage staff in a secure place and dispensed upon request.

(5) Any items sent through the mail or given by a visitor to a patient or resident become the personal property of that patient or resident and shall be handled in accordance with the procedures set forth in these rules.

(6) Prohibited items shall be handled as follows:

(a) The rules regarding the possession of prohibited items shall be discussed with the patient or resident and if the patient or resident is an unemancipated minor or legally incapacitated, the patient's or resident's parent or legal guardian, and such items shall be disposed of as follows:

(A) Given to the patient's or resident's parent, guardian, spouse, friend, attorney, or other person designated by the patient or resident;

(B) In the case of gifts, returned to the sender or giver;

(C) Kept in a secure location on the ward or cottage or central location of the institution for delivery to the patient or resident upon release or discharge from the institution; or

(D) Destroyed in the presence of at least two employees of the state institution.

(b) If agreement cannot be reached over the disposition of such items, the patient or resident may appeal the proposed disposition of prohibited items pursuant to the Division's grievance procedures in OAR 309-118-0000 through 309-118-0050. The state institution must retain the prohibited item in a secure location until a decision is made;

(c) The possession of items prohibited by law shall be turned over to the appropriate law enforcement authorities.

(7) Searches shall adhere to the following restrictions:

(a) Except for visual inspection of nose, mouth or ears without digital intrusion, all internal examinations must be conducted by either a physician or a nurse and only upon authorization of the superintendent or designee;

(b) Except for physicians and nurses, only same sex personnel shall carry out searches of a patient/resident's person except in emergencies;

(c) Upon completion of searches of a patient/resident's living area and personal property staff shall return the area to a neat and orderly condition and ensure that authorized property is in no way damaged or dispossessed.

(8) State institutions shall develop written procedures for handling missing personal property. These procedures may include the involvement of law enforcement authorities.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83; MHD 7-1986, f. & ef. 9-4-86

309-108-0020
Notice to Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 30-1982, f. 12-28-82, ef. 1-28-83

DIVISION 112

USE OF RESTRAINT FOR PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-112-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe policies and procedures concerning the use of restraint in the treatment, training, and behavior

management of patients and residents in state institutions operated by the Mental Health Division. In addition to these general rules, other more specific requirements established by federal regulations must be followed where applicable.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 426.070(6), 426.215(5), 426.385(3), and 427.031(4).

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84

309-112-0005
Definitions

As used in these rules:

(1) "Chief Medical Officer" means the physician designated by the superintendent of each state institution pursuant to ORS 179.360(1)(f) who is responsible for the administration of medical treatment and training at each state institution.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Interdisciplinary Team (IDT)" means a group of professional and direct care staff which has primary responsibility for the development of a plan for the care, treatment, and training of an individual patient or resident.

(4) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(5) "Qualified Mental Retardation Professional" means a person who meets the professional requirements prescribed by **42 CFR 442.401** or as amended.

(6) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(7) "Restraint" means one or more of the following procedures:

(a) "Lockdown" means locking all patients in state institutions for the mentally ill in their own rooms;

(b) "Personal Restraint" means a procedure in which a patient or resident is placed in a prone or supine position or held in a chair by another person in order to restrict the physical movement of the patient or resident;

(c) "Physical Restraint" means a device which restricts the physical movement of a patient or resident and which cannot be removed by the person and is not a normal article of clothing, a therapy device, or a simple safety device; or

(d) "Seclusion" means the placement of a patient or resident alone in a locked room.

(8) "Restraint Review Committee" means the committee appointed by the superintendent of each state institution as provided in OAR 309-112-0030.

(9) "Security Area" means a cottage or ward in which a program is conducted for dangerous patients or residents, including those judged guilty but not responsible, those court ordered into a secure program prior to trial, and those court committed patients or residents not manageable in less secure programs.

(10) "Security Transportation" means using physical restraint while a patient or resident is being transported outside a security area.

(11) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

(12) "Superintendent" means the executive head of the state institution as listed in section (11) of this rule.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 21-1982, f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 2-1986, f. & ef. 3-31-86

309-112-0010
General Policies Concerning Use of Restraint

(1) State institutions shall not use restraint except in emergencies, as provided in OAR 309-112-0015, or as part of planned treatment or training programs as provided in OAR 309-112-0017, and only then subject to the conditions and limitations of these rules. An order for physical restraint may not be in effect longer than 12 hours. No form of restraint shall be used as punishment, for the convenience of staff, or as a substitute for activities, treatment, or training.

(2) Under no circumstances may seclusion or lockdown be used in ICF/MR institutions.

(3) State institutions shall provide training in the appropriate use of restraint to all employees having direct care responsibilities.

(4) Medication will not be used as a restraint, but will be prescribed and administered according to acceptable medical, nursing, and pharmaceutical practices.

(5) Patients and residents shall not be permitted to use restraint on other patients or residents.

(6) Physical restraint must be used in accordance with sound medical practice to assure the least risk of physical injury and discomfort. Any patient or resident placed in physical restraint shall be protected from self-injury and from injury by others.

(7) Checking a patient or resident in restraint:

(a) A patient or resident in restraint must be checked at least every 15 minutes;

(b) Attention shall be paid to the patient's or resident's basic personal needs (such as regular meals, personal hygiene, and sleep) as well as the person's need for good body alignment and circulation;

(c) Staff shall document that the patient or resident was checked and appropriate attention paid to the person's needs.

(8) During waking hours the patient or resident must be exercised for a period not less than 10 minutes during each two hours of physical restraint. Partial release of physical restraint shall be employed as necessary to permit motion and exercise without endangering other staff and patients or residents.

(9) Unless the order authorizing use of restraint specifically provides otherwise, the patient or resident shall be released as soon as it is reasonable to assume that the behavior causing use of restraint will not immediately resume if the person is released.

(10) OAR 309-112-0015 and 309-112-0017 require staff of state institutions to apply the most appropriate form of restraint consistent with the patient's or resident's behavior requiring intervention, the need to protect the staff and other patients and residents, the patient's or resident's treatment or training needs and preservation of the patient's or resident's sense of personal dignity and self-esteem. The determination of the most appropriate intervention requires consideration of the following factors:

(a) The individual patient or resident involved; e.g., the present physical ability to engage in violent or destructive behavior, any preference the individual patient or resident has for one method of behavior management versus another, and the individual's reaction to various methods of intervention;

(b) The risk or degree of physical or psychological harm and discomfort that accompany the various methods of intervention;

(c) The risk or degree of interference with the individual's ongoing treatment or training and other activities.

(11) A summary of all uses of restraint, other than personal restraint for 15 minutes or less, shall be sent to the chief medical officer at least monthly.

(12) The following types of procedures are part of ordinary and customary medical care for physical illnesses or conditions and are not subject to the provisions of these rules:

(a) Holding or restraining a patient or resident during an examination, blood drawing, performance of a diagnostic test or during treatment for an acute medical condition;

(b) Restricting movement with orthopedic devices such as casts, wheel chairs, braces, and positioning devices;

(c) Isolating a patient or resident with a known or suspected infectious disease;

(d) Protecting seizure-prone and self-abusive patients and residents by the use of protective gear.

(13) A patient or resident, parent, guardian, or a duly authorized representative of the patient, resident, parent, or guardian has the right to contest any application of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions).

(14) Violation of the rights, policies, and procedures set forth in these rules by an employee of the Division constitutes cause for disciplinary action.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 21-1982, f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 16-1985(Temp), f. & ef. 10-9-85; MHD 2-1986, f. & ef. 3-31-86

309-112-0015
Use of Restraint in Emergencies

(1) Subject to the provisions of these rules, restraint may be used to manage the behavior of a patient or resident in emergencies. An emergency exists, as determined by the chief medical officer or designee if, because of the behavior of a patient or resident:

(a) There is a substantial likelihood of immediate physical harm to the patient, resident, or others in the institution; and

(b) There is a substantial likelihood of significant property damage; or

(c) The patient's or resident's behavior seriously disrupts the activities of other patients or residents on the ward or cottage; and

(d) Measures other than the use of restraint are deemed ineffective to manage the behavior.

(2)(a) When an emergency exists, the staff of a state institution shall select the most appropriate intervention consistent with OAR 309-112-0010(9);

(b) Whenever the interdisciplinary team (IDT) has reason to believe that in the course of a patient's or resident's care, custody, treatment, or training at a state institution it may become necessary to use restraint in an emergency, a member of the IDT shall, if practicable, ask the patient or resident for an expression of preference or aversion to the various forms of intervention. A member of the IDT shall also ask the parent or guardian for an expression of preference regarding forms of intervention. The patient's or resident's expression, if any, as well as that of the parent or guardian shall be relayed to the other IDT members and recorded in the patient's or resident's chart;

(c) The patient's or resident's wishes for or against particular forms of intervention shall be respected by the person authorizing the use of restraint, provided that primary consideration shall be given to the need to protect the patient or resident and others in the institution.

(3) Authorization:

(a) Except as provided in subsections (3)(d) and (e) of this rule, restraint shall be administered only pursuant to the order of the chief medical officer or the chief medical officer's designee;

(b) For the purposes of this section, the chief medical officer may designate one or more of the following persons: A physician licensed to practice medicine in the State of Oregon, a psychologist, or a qualified mental retardation professional;

(c) The chief medical officer or designee shall order the use of restraint only after adequately assessing the patient's or resident's condition and the environmental situation;

(d) If the chief medical officer or designee is not available immediately to assess the need for intervention, and an emergency exists as defined in section (1) of this rule:

(A) The person in charge of the ward or cottage at the time:

(i) May temporarily authorize the use of restraint for a period of time not to exceed 30 minutes; and

(ii) Shall contact the chief medical officer or designee at the earliest practical time.

(B) The chief medical officer or designee shall personally observe the patient or resident as soon as practicable to assess the individual and assess the appropriateness of the temporary use of restraint. The observation shall be documented in the person's chart.

(e) Personal restraints may be administered for up to 15 minutes, without specific authorization, by one or more staff persons with specific training in the use of personal restraints. Use of personal restraints in excess of 15 minutes must be ordered by the chief medical officer or designee or as provided in subsection (3)(d) of this rule. The order may be oral or written but shall be documented as provided in section (4) of this rule.

(4) Documentation:

(a) No later than the end of their work shifts, the persons who authorized and carried out the use of restraint shall document in the patient's or resident's chart including but not necessarily limited to:

(A) The specific behavior which required intervention;

(B) The method of intervention used and the patient's or resident's response to the intervention; and

(C) The reason this specific intervention was used.

(b) Within 24 hours after the incident resulting in the use of restraint, the chief medical officer or designee who ordered the intervention shall review and sign the documentation. In the case of patients detained in a psychiatric hospital pursuant to an emergency hold under ORS 426.175 through 426.215, the treating physician shall sign the documentation, if the treating physician is not the chief medical officer or designee who ordered the intervention.

(5) Time Limits: All orders authorizing use of restraint shall contain an expiration time, not to exceed 12 hours and consistent with OAR 309-112-0010(8). Upon personal re-examination of the patient or resident, the chief medical officer or designee may extend the order for up to 12 hours at each review, provided that the behavior of the patient or resident justifies extended intervention. After each 24 hours of continuous restraint, a second opinion from another designee of the chief medical officer shall be required for further extension of the restraint.

(6) Reporting: Under this rule all emergency uses of restraint in excess of 15 minutes shall be reported daily to the chief medical officer or designee.

(7) After the second use of emergency restraint on a particular patient or resident during a one-month period, a treatment program designed to reduce the need for restraint must be developed.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84; MHD 2-1986, f. & ef. 3-31-86

309-112-0017
Use of Restraint as Part of Planned Treatment or Training Programs

Subject to the provisions of these rules, restraint may be used as part of planned treatment or training programs provided the informed consent of the patient or resident is obtained or, if informed consent cannot be obtained, authorization to proceed with necessary treatment or training is obtained as provided in OAR 309-114-0000 through 309-114-0025.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 11-1982(Temp), f. & ef. 6-10-82; MHD 21-1982, f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84

309-112-0020
Use of Lockdown and Security Transportation

(1) The chief medical officer or designee may authorize the use of a "lockdown" in a security area in a state institution for the mentally ill:

(a) In order to carry out a search of the security area;

(b) When insufficient staff are present to safely manage the security area; and

(c) When any condition develops which, in the opinion of the chief medical officer, requires lockdown to maintain safety in the security area or to protect the public.

(2) The chief medical officer or designee may authorize the use of secure transportation for patients or residents of a secure program when outside the security area.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84

309-112-0025
Use of Restraint for Acute Medical Conditions

(1) During medical treatment for acute physical conditions, personal and physical restraint may be used to prevent a patient or resident from injuring himself or herself.

(2) Use of a restraint in the presence of a physician may be authorized verbally; ongoing or continuing use of personal or physical restraint must be ordered in writing by a physician.

(3) Treatment staff shall:

(a) Attend to the patient's or resident's basic personal needs and exercise needs in accordance with general medical practice; and

(b) To the extent practicable, accommodate the patient's or resident's mental disabilities treatment and training regimen.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84

309-112-0030
Restraint Review Committee

(1) Each state institution shall have a Restraint Review Committee. The members of the committee shall be appointed by the super-

intendent of each institution and shall consist of five members; two from institution staff and three community persons who are knowledgeable in the field of mental health or mental retardation, as appropriate. A quorum shall consist of three members. The committee may be one formed specifically for the purposes set forth in this rule, or the duties prescribed in this rule may be assigned to an existing committee.

(2) The purpose and duty of the Restraint Review Committee is to review and evaluate at least quarterly the appropriateness of all such interventions and report its findings to the superintendent.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 12-1982, f. & ef. 6-10-82; MHD 22-1982(Temp), f. & ef. 9-24-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84

309-112-0035
Notice to Patients, Residents, and Employees

(1) Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple statement of the title and number of these rules, their general purpose, and instructions on how to obtain a copy of the rules and how to seek advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time of the effective date of these rules, of the rights, policies, and procedures set forth in these rules.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 1-1982(Temp), f. & ef. 1-14-82; MHD 7-1982, f. & ef. 3-29-82; MHD 1-1984, f. 1-20-84, ef. 2-1-84

DIVISION 114

INFORMED CONSENT TO TREATMENT AND TRAINING BY PATIENTS AND RESIDENTS IN STATE INSTITUTIONS

309-114-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures to be observed by personnel of state institutions operated by the Mental Health and Developmental Disability Services Division in obtaining informed consent to significant procedures, as defined by these rules, from patients and residents of such state institutions. These rules do not apply to routine medical procedures. The purpose of these rules is to assure that the rights of patients and residents are protected with respect to significant procedures.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 179.321, 426.070(6), 426.385(1)(L), (2), and (3), 427.031(3) and (4), and 427.255(2), insofar as these statutes in whole or in part relate to treatment or training of persons admitted or committed to state institutions operated by the Mental Health and Developmental Disability Services Division.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83

309-114-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Chief Medical Officer" means the physician designated by the superintendent of each state institution pursuant to ORS 179.360(1)(f) who is responsible for the administration of medical treatment at each state institution.

(3) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(4) "Guardian" means a legal guardian, person appointed by a court of law to act as guardian of a minor or a legally incapacitated person.

(5) "Legally Incapacitated" means having been found by a court of law under ORS 126.103 or 426.295 to be unable, without assistance, to properly manage or take care of one's personal affairs.

(6) "Material Risk." A risk is material if it may have a substantial adverse effect on the patient's or resident's psychological and/or physical health. Tardive dyskinesia is a material risk of neuroleptic medication.

(7) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(8) "Person Committed to the Division" or "person" means a patient or resident committed under ORS 161.327, 161.370, 179.478, 426.130, or 427.215, or certified by the State Training Center Review Board under ORS 427.020.

(9) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(10) "Significant Procedure" means a diagnostic or treatment modality which poses a material risk of substantial pain or harm to the patient or resident such as, but not limited to, psychotropic medication and electro-convulsive therapy.

(11) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Psychiatric Center and Eastern Oregon Training Center in Pendleton.

(12) "Superintendent" means the executive head of the state institution listed in section (11) of this rule, or the superintendent's designee.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert. ef. 6-1-88

309-114-0010
General Policy on Obtaining Informed Consent to Treatment and Training

(1) Basic Rule. Patients and residents, or parents or guardians of minors, or guardians on behalf of legally incapacitated patients and residents, may refuse any significant procedure and may withdraw at any time consent previously given to a significant procedure. Any refusal or withdrawal or withholding of consent shall be documented in the patient's or resident's record. Personnel of a state institution shall not administer a significant procedure to a patient or resident unless written informed consent is obtained from or on behalf of the patient or resident in the manner prescribed in these rules, except as follows:

(a)(A) Administration of significant procedures to legally incapacitated patients or residents as provided in section (6) of this rule;

(B) Administration of significant procedures without informed consent in emergencies (OAR 309-114-0015); and

(C) Involuntary administration of significant procedures with good cause to persons committed to the Division (OAR 309-114-0020).

(b) In no case may personnel of a state institution for the mentally retarded administer a procedure using aversive stimuli to a resident without the consent of a parent or legal guardian.

(2) Capacity of patient or resident: The patient or resident from whom informed consent is being sought must have the capacity to make a decision concerning acceptance or rejection of a significant procedure, as follows:

(a) Unless adjudicated legally incapacitated for all purposes or for the specific purpose of making treatment decisions, a patient or resident shall be presumed competent to consent to, or refuse, withhold, or withdraw consent to significant procedures. A person committed to the Division may be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure only if the person currently demonstrates an inability to comprehend and weigh the risks and benefits of the proposed procedure, alternative procedures, or no treatment at all or other information disclosed pursuant to subsections (3)(a) and (b) of this rule. Such inability is to be documented in the person's record and supported by documented statements or behavior of the person and may be evidenced in forms provided for obtaining informed consent by treating physicians, evaluations by independent examining physicians, review by disposition boards in the case of a resident, and approved or disapproved by the superintendent or chief medical officer;

(b) A person committed to the Division shall not be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure merely by reason of one or more of the following facts:

(A) That the person has been involuntarily committed to the Division;

(B) That the person has been diagnosed as mentally ill or mentally retarded;

(C) That the person has disagreed or now disagrees with the treating physician's diagnosis;

(D) That the person has disagreed or now disagrees with the treating physician's recommendation regarding treatment.

(c) If a court has determined that a patient or resident is legally incapacitated, then consent shall be sought from the legal guardian.

(3)(a) Procedures for Obtaining Informed Consent and Information to be Given: The person from whom informed consent to a significant procedure is sought shall be given information, orally and in writing, the substance of which is to be found on an informed consent form similar to that set out in the attached **Example A**. In the case of medication, there shall be attached a preprinted patient information sheet on the risks and benefits of the medication;

(b) The information shall at least describe:

(A) The nature and seriousness of the patient's or resident's mental illness or condition;

(B) The purpose of the significant procedure, its intended outcome and the risks and benefits of the procedure;

(C) Any alternatives, particularly alternatives offering less material risks to the proposed significant procedure that are reasonably available and reasonably comparable in effectiveness;

(D) If the proposed significant procedure is medication, the physician shall give the name, dosage, frequency, and duration of administration of the medication, and shall explain the material risks of the medication at that dosage. Tardive dyskinesia is a material risk of neuroleptic medication;

(E) The side effects of intended medication and electrotherapy;

(F) The predicted medical/psychiatric consequences of not accepting the significant procedure or any comparable procedure;

(G) That consent may be refused, withheld or withdrawn at any time; and

(H) Any additional information concerning the proposed significant procedure requested by the person.

(c) The physician intending to administer a significant procedure shall document in the patient's or resident's chart that the information required in subsections (3)(a) and (b) of this rule was explained and that the patient, resident, parent or guardian of a minor or guardian of a legally incapacitated patient or resident explicitly consented, refused, withheld or withdrew consent. The physician shall also complete the informed consent form and make it part of the person's record.

(4) When informed consent is sought, a reasonable opportunity to obtain and present additional information relevant to making this decision shall be given.

(5) Voluntary Consent: Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion. Subject to the provisions of OAR 309-114-0020 (Involuntary Administration of Significant Procedures to Committed Patients and Residents With Good Cause to persons committed to the Division), the decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing withholding to or withdrawing consent. A voluntary patient or resident may be discharged from the institution if offered procedures are refused.

(6) Obtaining Consent with Respect to Legally Incapacitated Patients and Residents: A state institution may not administer a significant procedure to a legally incapacitated patient or resident without the consent of the guardian, or, in the case of a minor, the parent or guardian, except in the case of an emergency.

(7) Reports of Progress: A patient or resident, the parents or guardian of a minor patient or resident, or the guardian of a legally incapacitated patient or resident shall, upon request, be informed of the progress of the patient or resident during administration of the significant procedure.

(8) Contest of Rules: A patient or resident has the right to contest the application of any provision of these rules as provided in OAR 309-118-0000 through 309-118-0050 (Grievance Procedures for Use in State Institutions). Grievances filed under OAR 309-118-0000 through 309-118-0050, as they pertain to informed consent, will exclude Level 1 resolution and will be submitted directly to a Grievance Committee Hearing (Level 2). All other aspects of OAR 309-118-0000 through 309-118-0050 will apply. If the patient or resident is a minor or legally incapacitated , the parents or guardian has the right to contest the application of any provision of these rules by using the grievance procedures.

[ED. NOTE: Examples referenced are available from the agency.]

Stat. Auth.: ORS 179, 426, 427 & 430

Stats. Implemented:

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert. ef. 6-1-88

309-114-0015

Administration of Significant Procedures Without Informed Consent in Emergencies

(1) An emergency exists if in the opinion of the chief medical officer or designee:

(a) Immediate action is required to preserve the life or physical health of the patient or resident and it is impracticable to obtain informed consent as provided in OAR 309-114-0010; or

(b) Immediate action is required because the behavior of the patient or resident creates a substantial likelihood of immediate physical harm to the patient, resident, or others in the institution and it is impracticable to obtain informed consent as provided in OAR 309-114-0010.

(2) If an emergency exists, the chief medical officer or designee may administer a significant procedure to a patient or resident without obtaining prior informed consent in the manner otherwise required by these rules provided:

(a) The specific nature of each emergency and the procedure which was used to deal with the emergency are adequately documented in the patient's or resident's record and a form provided for emergency procedure is completed and placed in the patient's or resident's record. An example of this form is attached to these rules as **Example B**;

(b) Reasonable effort shall be made to contact the parent or legal guardian prior to the administration of the significant procedure. If contact is not possible, notice shall be given to the parent or legal guardian as soon as possible;

(c) Within a reasonable period of time after an emergency procedure is administered, the treatment team shall review the treatment or training program and, if practicable, implement a treatment or training program designed to correct the behavior creating the emergency;

(d) The administration of a significant procedure in an emergency situation does not allow the institution to administer these procedures, once the emergency has subsided, without obtaining informed consent.

[ED. NOTE: Examples referenced are available from the agency.]

Stat. Auth.: ORS 179, 426, 427 & 430

Stats. Implemented:

Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert. ef. 6-1-88

309-114-0020

Involuntary Administration of Significant Procedures to Persons Committed to the Division with Good Cause

(1) Good cause: Good cause exists to administer a significant procedure to a person committed to the Division without informed consent if in the opinion of the treating physician after consultation with the treatment team:

(a) The person is deemed unable pursuant to OAR 309-114-0010(2) to consent to, refuse, withhold or withdraw consent to the significant procedure;

(b) The proposed significant procedure will likely restore, or prevent deterioration of, the person's mental or physical health; alleviate extreme suffering; or save or extend the person's life;

(c) The proposed significant procedure is the most appropriate treatment for the person's condition according to current clinical practice, and all other less intrusive procedures have been considered and all criteria and information set forth in OAR 309-114-0010(3)(b) are considered;

(d) The treating physician or qualified mental retardation professional has made a conscientious effort to obtain informed consent to the significant procedure from the person. A "conscientious effort" means a good faith attempt to obtain informed consent by attempting to explain the procedure more than one time and at different times and shall so be recorded in the person's record.

(2)(a) Independent Review: Prior to granting approval for the administration of a significant procedure for good cause to a person

committed to the Division, the superintendent or chief medical officer of a state institution for the mentally ill shall obtain consultation and approval from an independent examining physician. The superintendent or chief medical officer shall maintain a list of independent examining physicians and shall seek consultation and approval from independent examining physicians selected on a rotating basis from the list. The independent examining physician shall not be an employee of the Division, shall be a board-eligible psychiatrist, shall have been subjected to review by the medical staff executive committee as to qualifications to make such an examination, shall have been provided with a copy of administration rules OAR 309-114-0000 through 309-114-0025, and shall have participated in a training program regarding these rules, their meaning and application;

(b) Prior to granting approval for the administration of a significant procedure for good cause, the superintendent or chief medical officer of a state institution for the mentally retarded shall refer the matter for review to a disposition board convened for such purpose. The disposition board shall have five members; two of which are employees of the institution not directly involved in the treatment of the resident in question, and three public members. Members of the disposition board shall be provided a copy of administrative rules OAR 309-114-0000 through 309-114-0025 and shall be part of a training program regarding their meaning and application;

(c) The superintendent or chief medical officer shall provide to a patient or resident to whom a significant procedure is proposed to be administered written advance notice of the intent to seek consultation and approval of an independent examining physician or review by a disposition board for the purpose of administering the procedure without the person's consent.

(3) The physician selected to conduct the independent consultation or the disposition board shall:

(a) Review the person's medical chart, including the records of efforts made to obtain the person's informed consent, personally examine the person, or, in the case of the disposition board, interview the resident;

(b) Discuss the matter with the person to determine the extent of the need for the procedure and the nature of the person's refusal, withholding, or withdrawal or inability to consent to the significant procedure;

(c) Consider additional information, if any, presented prior to or at the time of examination or interview as may be requested by the person or anyone on behalf of the person;

(d) Make a determination whether the factors required under these rules exist for the particular person or that one or more factors are not present, and complete a report of their findings on a form substantially similar to that attached to these rules as an example, which provides their approval or disapproval of the proposed significant procedure to:

(A) The superintendent or chief medical officer; and

(B) The person to whom a significant procedure is proposed to be administered, with a copy being made part of the person's record.

(4)(a) Superintendent's Determination: The superintendent or chief medical officer shall approve or disapprove of the administration of the significant procedure to a person committed to the Division based on good cause, provided that if the examining physician or disposition board found that one or more of the factors required by section (1) of this rule were not present or otherwise disapproved of the procedure, the superintendent or chief medical officer shall not approve the significant procedure and it shall not be performed;

(b) Approval of the significant procedure shall be only as long as no substantial increase in risk is encountered in administering the significant procedure during the term of a person's commitment but in no case longer than one year. Disapproval shall be only as long as no substantial change occurs in the person's condition during the term of commitment but in no case longer than one year;

(c) Written notice of the superintendent's or chief medical officer's determination shall be provided to the person and made part of the person's record;

(d) Records of all reports by independent examining physicians or disposition boards and of the determinations of the superintendent or chief medical officer under this rule shall be maintained by the superintendent or chief medical officer in a separate file and shall be summarized each year. Such summaries shall show:

(A) Each type of proposed significant procedure for which consultation with an independent examining physician or review by a disposition board was sought;

(B) The number of times consultation or review was sought from a particular independent examining physician or disposition board for each type of proposed significant procedure;

(C) The number of times each independent examining physician or disposition board approved and disapproved each type of proposed significant procedure; and

(D) The number of times the superintendent or chief medical officer approved and disapproved each type of proposed significant procedure;

(E) Such summaries shall be public records and shall be made available to the public during reasonable business hours in accordance with ORS Chapter 192.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-880, cert. ef. 6-1-88

309-114-0025
Notice to Patients, Residents, and Employees

(1) Upon a patient's or resident's admission, the state institutions shall inform the patient and resident, orally and in writing, of the rights, policies, and procedures set forth in these rules. In addition, a clear and simple summary of the contents, including the title, number, and purpose of these rules, and instructions on how to obtain a copy of the rules and advice about their content shall be prominently displayed in areas frequented by patients and residents in all state institutions.

(2) All employees of state institutions involved in patient or resident care shall be notified in writing at the commencement of their employment, or, for present employees, within a reasonable time after the effective date of these rules, of the rights, policies, and procedures set forth in these rules. These employees shall participate in a training program regarding the rules, their meaning and application.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 3-1983, f. 2-24-83, ef. 3-26-83; MHD 3-1988, f. 4-12-88, (and corrected 5-17-88), cert ef. 6-1-88

DIVISION 118

GRIEVANCE PROCEDURES FOR USE IN STATE INSTITUTIONS

309-118-0000
Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for establishing grievance procedures, other than contested cases, for use by patients and residents of state institutions operated by the Mental Health and Developmental Disability Services Division.

(2) Statutory Authority. These rules are authorized by ORS 430.041 and 179.040 and carry out the provisions of ORS 426.385 and 427.031. These rules were adopted and filed with the Secretary of State on July 9, 1982.

(3) Effective Date. These rules are effective July 23, 1982.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0005
Definitions

As used in these rules:

(1) "Administrator" means the Assistant Director, Human Resources, and Administrator for Mental Health.

(2) "Division" means the Mental Health and Developmental Disability Services Division of the Department of Human Services.

(3) "Emergency Grievance" means a grievance that:

(a) Is likely to cause irreparable harm to a substantial right of a patient or resident before completion of the grievance procedures set forth in OAR 309-118-0020; and

(b) Appears likely to be resolved in favor of the patient or resident.

(4) "Grievance" means a complaint about:

(a) The substance or application of any rule or written or unwritten policy of the Division or any of its state institutions affecting a patient or resident;

(b) The lack of a rule or policy concerning a matter affecting a patient or resident; or

(c) Any decision or action directed toward a patient or resident by the Division or any of the Division's employees or agents. (See also OAR 309-118-0015.)

(5) "Interdisciplinary Team (IDT)" means a group of professional and direct care staff which has primary responsibility for the development of a plan for the care, treatment, and training of an individual patient or resident.

(6) "Patient" means a person who is receiving care and treatment in a state institution for the mentally ill.

(7) "Representative" means a person who acts on behalf of a patient or resident with respect to a grievance, including, but not limited to a relative, friend, employee of the Division, attorney or legal guardian. (See also OAR 309-118-0030.) In no case, may another patient or resident act as the representative of a grieving patient or resident.

(8) "Resident" means a person who is receiving care, treatment, and training in a state institution for the mentally retarded.

(9) "State Institution" means Dammasch State Hospital in Wilsonville, Oregon State Hospital in Salem, Fairview Training Center in Salem, and Eastern Oregon Hospital and Training Center in Pendleton.

(10) "Superintendent" means the executive head of the state institution as listed in section (9) of this rule.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0010
Policy Statement

(1) It is the policy of the Mental Health and Developmental Disability Services Division that care, training, and treatment of patients and residents in state institutions should be administered in a manner that preserves the human, civil, and legal rights of patients and residents. It is in the interests of patients, residents, state institutions, and the Division that each state institution should develop and maintain a system for patients, residents, and their representatives to identify and resolve within the Division grievances concerning care, treatment, training, and patient and resident rights.

(2) The Division recognizes the responsibility and authority of other state and federal agencies to receive and review complaints from patients, residents, and their representatives. No patient or resident shall be subjected to reprisal for contacting or seeking review of a grievance outside the Division, or pursuant to the state institution's grievance procedures.

(3) Patients and residents have varying abilities to verbalize grievances and comply with procedures for presenting a formal grievance, therefore:

(a) Staff of the state institutions have a responsibility to assist patients, residents, and their representatives to articulate grievances and use the grievance procedures to resolve them;

(b) Persons charged with the responsibility for administering the grievance procedures set forth in these rules shall do so with flexibility to the end that a fair resolution of each grievance is accomplished within the Division.;

(c) Representatives and staff of state institutions who assist patients, residents and representatives in using the grievance procedures shall not be disciplined or otherwise subjected to reprisal, provided that such persons act in good faith and for the purpose of protecting the rights of patients and residents.

(4) The grievance procedures shall be administered in such a manner as to protect any right of a patient or resident to maintain the confidentiality of records and communications.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0015
Non-Grievable Issues

Notwithstanding the definition of a grievance in OAR 309-118-0005(4), an issue may not be processed through the grievance procedures set forth in these rules if there is a contested case hearing or other separate process recognized by statute or administrative rule that affords notice and opportunity to be heard before an impartial decision-maker concerning that issue; e.g., institutional reimbursement orders and judicial certifications of continuing mental illness or mental retardation.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0020
Grievance Procedures

(1) Informal Resolution. Whenever possible, a patient, resident, or representative should attempt to present and resolve grievances informally with the person or persons causing or involved in the area of complaint.

(2) Level 1 — Resolution by the interdisciplinary team. If a patient, resident, or representative cannot resolve a grievance through informal means, such person may submit a formal grievance statement to the patient's or resident's interdisciplinary team, as follows:

(a) A formal grievance must be in writing and may be on a form provided by the Division MHD-ADMS-0307. A formal grievance statement shall include at least the nature of the grievance and the proposed resolution;

(b) Copies of the grievance statement shall be forwarded to the superintendent of the state institution and to the grievance committee (described in OAR 309-118-0045) by the interdisciplinary team. In the event that the patient, resident, or representative fails or is unable to do so, the interdisciplinary team shall forward copies of the grievance statement to the superintendent and the grievance committee;

(c) Within 20 days after receiving the grievance statement, the interdisciplinary team shall:

(A) Discuss the matter personally with the person who filed the grievance, and if the grievance was filed by a representative, with the patient or resident; and may contact other persons alleged or appearing to be involved in the grievance;

(B) Consider any information furnished by the patient, resident, or representative and such other information as may be relevant and material to the grievance;

(C) Prepare a written response to the grievance containing at least findings of fact and the interdisciplinary team's resolution of the grievance;

(D) Provide a copy of the report to the patient or resident, and representative, if any, and to the superintendent and the grievance committee.

(3) Level 2 — Grievance committee hearing. The patient, resident, or representative may request the grievance committee to review the grievance for any of the following reasons: failure of the treatment team to dispose of the grievance within 20 days after submission of the grievance; dissatisfaction with the interdisciplinary team's decision; or dissatisfaction with implementation of the decision. The procedure shall be as follows:

(a) A request for review must be in writing and may be on a form provided by the Division MHD-ADMS-0308. A request for review shall state the person's reason for seeking review, and should have attached to it a copy of the original grievance statement and, if available, the IDT report;

(b) Copies of the request will be given to the interdisciplinary team and superintendent. In the event that the patient, resident, or representative fails or is unable to do so, the interdisciplinary team shall forward copies as required in this paragraph;

(c) As a general rule, a request for review shall be filed within 14 days after the interdisciplinary team files its report. However, a patient, resident, or representative shall be permitted to file a formal grievance beyond the 14 days for good cause;

(d) The grievance committee shall send a written acknowledgement to the patient, resident, or representative that the request for review has been received. The grievance committee shall hold a hearing within 21 days after receipt of a request for review;

(e) With respect to the grievance committee hearing, the patient or resident has the right:

(A) To three days' written notice of the date, time, and place of the hearing;

(B) To be represented by the person of the patient's or resident's choice, including legal counsel, at the expense of the patient or resident;

(C) To call witnesses and question witnesses called by the grievance committee or state institution; and

(D) To offer written information as evidence.

(f) Grievance committee hearings shall be conducted as informally as possible consistent with the need for an orderly and complete presentation of the grievance. The rules of evidence for judicial proceedings are not applicable to grievance committee hearings. However, in resolving a grievance, the grievance committee shall consider only information of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs;

(g) The grievance committee shall have 21 days after completion of the hearing to decide the matter and make the decision known to the patient, resident, or representative. A written report containing at least findings of fact and the committee's resolution of the grievance shall be prepared and signed by the presiding member of the grievance committee within 21 days after completion of the hearing;

(h) The written report of the grievance committee's decision shall be given to the patient, resident, or representative, if any, and the superintendent.

(4) Level 3 — Review by the superintendent:

(a) The patient, resident, or representative may request the superintendent to review the grievance for: Failure of the grievance committee to make a decision within 21 days after completion of the hearing; dissatisfaction with the grievance committee's decision; or dissatisfaction with implementation of the decision. The following procedures shall be observed:

(A) A request for review must be in writing and must indicate the reasons for requesting review by the superintendent;

(B) The superintendent shall send a written acknowledgment to the patient, resident, or representative that the request for review has been received;

(C) The superintendent shall review the report of the grievance committee and may take such other action to investigate the matter as the superintendent deems appropriate;

(D) The superintendent shall prepare a written report affirming or modifying the grievance committee's decision concerning the grievance, and shall give copies of the report to the patient, resident or the representative, if any, and to the grievance committee.

(b) The superintendent, as executive head of the state institution, has the right, with good cause, to veto the implementation of any proposed resolution of a grievance. Good cause includes, but is not limited to, where the resolution proposed exceeds the authority of the institution to implement.

(5) Level 4 — Review by the Administrator. If the patient, resident, or representative is dissatisfied with the superintendent's disposition of the grievance, the person may request the Administrator of the Division to review the matter. The following procedures shall be observed:

(a) A request for review must be in writing and must indicate the reasons for the person's dissatisfaction with the superintendent's action;

(b) The Administrator shall send a written acknowledgment to the patient, resident, or representative that the request for review has been received;

(c) The Administrator shall review the superintendent's report and may take such other action to investigate the matter as the Administrator deems appropriate; and

(d) The Administrator shall prepare a written report of the decision in response to the request for review of the grievance, and shall give copies of the report to the patient, resident, or representative, if any, and to the superintendent and grievance committee;

(e) Review by the Administrator is final. The Administrator's decision is not subject to appeal.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0025
Emergency Grievances

(1) If a patient, resident, or representative believes that the grievance is an emergency grievance, the patient, resident or representative may submit the formal grievance statement directly to the grievance committee.

(2) The grievance committee shall make a preliminary assessment of whether the grievance appears to be an emergency grievance and shall:

(a) Hear or investigate the matter and make a decision;

(b) If it appears that the grievance is not an emergency grievance, send the matter to the interdisciplinary team for attempted resolution; or

(c) Devise such other means to respond to the grievance as may be acceptable to the aggrieved party and the state institution.

(3) If the grievance is alleged patient or resident abuse as defined in administrative rules on patient or resident abuse, then the patient, resident, representative, interdisciplinary team, or grievance committee shall submit the matter to the superintendent of the institution. If a patient, resident, or representative is dissatisfied with the superintendent's response to an allegation of patient or resident abuse, the patient or resident may appeal to the Administrator of the Division.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0030
Representatives

(1) A patient or resident shall have the right not to be represented at all or to select the person who will act as the person's representative. The selected representative shall be respected at all levels of the grievance procedures.

(2) Staff members and other interested persons are encouraged to speak up on behalf of patients and residents who are limited in their ability to speak or act for themselves. However, the Division recognizes that a person claiming to be a representative may be acting without authority from, or against the wishes of, such patients and residents.

(3) At any level of the grievance procedures, the issue can be raised whether the claimed representative has the authority to act on behalf of the patient or resident involved. There may be an inquiry into whether the patient or resident understands that the claimed representative is acting on their behalf with respect to the subject matter of the grievance and whether the patient or resident objects to the representative:

(a) If it is found that the patient or resident understands the situation and does not object, the representative shall be deemed to be acting on the person's behalf;

(b) If it is found that the patient or resident understands the situation and objects to the representative, the claimed representative shall be deemed not to have the authority to act on behalf of the person;

(c) If it is found that the patient or resident does not understand the situation or is unable to indicate objection or lack of objection, the interdisciplinary team, grievance committee, superintendent or designee, or Administrator or designee shall:

(A) Make a judgment whether the claimed representative is acting in the best interest of the patient or resident and either allow or disallow the claimed representative to proceed on behalf of the patient or resident involved; and

(B) If the claimed representative is not allowed to proceed, assist the patient or resident in obtaining a representative or appoint a representative.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0035
Staff Role in Grievance Procedures

(1) The superintendent shall ensure that there is at least one staff person on each ward or cottage who has the responsibility for assisting, on an "as requested basis," the patient, resident, or representative to move through the grievance procedures. At the conclusion of each level of the grievance procedures, the designated staff person should make the patient, resident or representative aware of the next level in the procedures.

(2) The superintendent and other employees of the Division at a state institution shall cooperate with the grievance committee in the resolution of grievances.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0040
Review by Courts

Nothing in these rules is intended to affect the right of a patient or resident to seek independent redress of grievances by access to state or federal courts. These rules do not create a contested case subject to judicial review.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0045
Grievance Committee

(1) Each state institution shall have a grievance committee appointed by the superintendent.

(2) Each grievance committee shall have a minimum of five members, each with one or more alternates, designated by the superintendent, three of whom shall not be employees of the Division.

(3) Each grievance committee shall have the following duties:

(a) Serve as the second level in the state institution's grievance procedures;

(b) Receive and dispose of all emergency grievances submitted to the committee; and

(c) Review all formal grievances and resolutions, for the purpose of advising the superintendent regarding poorly resolved grievances and patterns of grievances.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

309-118-0050
Posting of Grievance Procedures

Upon admission, state institutions shall inform patients and residents, orally and in writing, of the rights, policies, and procedures set forth in these rules. A clear and simple statement of the grievance procedures shall be prominently posted in areas frequented by patients and residents, including each ward and cottage of the state institutions. Copies of the Grievance Statement and Request of a Grievance forms shall be accessible and available to patients and residents and their representatives.

Stat. Auth.: ORS 179, 426, 427 & 430
Stats. Implemented:
Hist.: MHD 15-1982, f. 7-9-82, ef. 7-23-82

DIVISION 120

PATIENT TRANSFERS

Assignment and Transfer of Inmates

309-120-0070
Purpose

These rules prescribe procedures by which offenders in Oregon Youth Authority (OYA) close custody facilities may be transferred to a state mental hospital or a facility designated by the Department of Human Services (DHS) for evaluation and treatment.

Stat. Auth.: ORS 179.040, 179.473, 179.475, 420.500 & 420.505
Stats. Implemented: ORS 179.040, 179.473, 179.475, 420.500 & 420.505
Hist.: MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06; MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06

309-120-0075
Definitions

As used in these rules:

(l) "Close custody facility" means any of the secure facilities operated by the OYA, including, but not limited to, youth correctional facilities, work/study camps, and transition camps.

(2) "Facility designated by the Department of Human Services (DHS)" means a hospital or secure non-hospital facility designated by DHS to provide evaluation and treatment services for offenders under the age of 18.

(3) "Hearing Officer" means an independent decision maker designated to conduct an administrative commitment hearing for an offender.

(4) "Mentally ill offender" means an offender who, because of a mental disorder or a severe emotional disorder, is one or more of the following:

(a) Dangerous to self or others;

(b) Is unable to provide for basic personal needs and is not receiving such psychiatric care as is necessary for health or safety; or

(c) An offender, who unless treated, will continue, with a reasonable medical probability, to physically or mentally deteriorate so that the offender will become a person described under either or both subparagraph (4)(a) or (4)(b) of this rule.

(5) "Offender" means a person placed in OYA close custody facility, including inmates in the legal custody of the Department of Corrections (DOC).

(6) "State Mental Hospital" as defined in ORS 426.010. Except as otherwise ordered by the DHS pursuant to ORS 179.325, the Oregon State Hospitals in Salem, Marion County, and Portland, Multnomah County, and the Blue Mountain Recovery Center in Pendleton, Umatilla County, will be used as state hospitals for the care and treatment of mentally ill offenders age 18 and over who are transferred by the OYA pursuant to these rules.

Stat. Auth.: ORS 179.040, 179.473, 179.475, 420.500 & 420.505
Stats. Implemented: ORS 179.040, 179.473, 179.475, 420.500 & 420.505
Hist.: MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06; MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06

309-120-0080
Procedures for Transfer

(l) The OYA close custody facility Superintendent, the Director of the OYA, or the Director's designee may request that the Superintendent of a state mental hospital or a facility designated by DHS for evaluation and treatment accept a transfer of a mentally ill offender to a state mental hospital or facility designated by DHS.

(2) If the Superintendent of the state mental hospital or facility designated by DHS approves a transfer request made under paragraph (1) of this rule, the offender will be transferred.

(3) An offender may be transferred to a state mental hospital or a facility designated by DHS for stabilization and evaluation for mental health treatment for a period not to exceed 30 days unless the transfer is extended with offender consent or following an administrative commitment hearing pursuant to paragraph (4) of this rule.

(4) Administrative commitments for offenders in the legal custody of the DOC and in the physical custody of the OYA will be accomplished through a hearing conducted by an OYA hearing officer in accordance with these rules. DOC offenders in OYA physical custody requiring mental health evaluation and treatment will be transferred directly from an OYA facility to a state mental hospital listed in ORS 426.010 or a hospital or facility designated by DHS and returned directly to the OYA facility.

(5) The DHS will provide for an administrative commitment hearing conducted by a hearing officer employed or under contract with the OYA for administrative commitment or extension of the transfer of the offender if:

(a) The DHS determines that administrative commitment for treatment for a mental illness is necessary or advisable or that DHS needs more than 30 days to stabilize or evaluate the offender; and

(b) The offender does not consent to the administrative commitment or an extension of the transfer.

(6) The administrative commitment hearing process will, at a minimum, include the following procedures:

(a) Not less than 24 hours before the administrative commitment hearing is scheduled to occur, the hearing officer will provide written notice of the hearing to the offender and the offender's parent/guardian if the offender is less than 18 years of age.

(b) The notice will include the following information:

(A) A statement that an administrative commitment to a state mental hospital listed in ORS 426.010 or a facility designated by DHS, or an extension of the transfer, is being considered.

(B) A concise statement of the reason for administrative commitment or extension of the transfer.

(C) The offender's right to a hearing.

(D) The time and place of the hearing.

(E) Notice that the purpose of the administrative commitment hearing is to determine whether there is clear and convincing evidence that the offender is a mentally ill person as defined in ORS 426.005 such that administrative commitment or an extension of the transfer is warranted.

(F) The names of persons who have given information relevant to of the administrative commitment or extension of the transfer, and the offender's right to have these persons present at the administrative

commitment hearing for the purposes of confrontation and cross-examination.

(G) The offender's right to admit or deny the allegations and present letters, documents, affidavits, or persons with relevant information at the administrative hearing in support of his/her defense or contentions, subject to the exclusions and restrictions provided in these rules.

(H) The offender's right to be represented by an attorney at his/her own expense. Assistance by a qualified and independent person approved by the hearing officer will be ordered upon a finding that assistance is necessary based upon the offender's financial inability to provide an assistant, language barriers, or competence and capacity of an offender to prepare a defense, to understand the proceedings, or to understand the rights available to him or her. An offender subject to an administrative commitment hearing may not receive assistance from another offender.

(I) A copy of this rule.

(c) The administrative commitment hearing will be held no more than five (5) days from the date of the written notice of the hearing.

(A) Prior to the commencement of the administrative commitment hearing, the hearing officer will furnish the offender a written explanation of the proceedings.

(B) The administrative commitment hearing will be conducted by a hearing officer employed or under contract with the OYA. The hearing officer will not have participated in any previous way in the assessment process.

(C) At the administrative commitment hearing, the offender will have an opportunity to be heard in person and through his/her attorney or independent assistant, if any.

(d) The administrative commitment hearing will be conducted in the following manner.

(A) Statement and evidence of the DHS in support of the action.

(B) Statement and evidence of the offender.

(C) Questioning, examination, or cross-examination of witnesses, unless in the opinion of the hearing officer an informant or witness would be subjected to risk of harm if his/her identity is disclosed.

(i) The offender's attorney or assistant, if any, may cross-examine witnesses, unless the hearing officer determines that it is necessary to deny cross-examination to preserve the anonymity of the witness.

(ii) If the offender has no attorney, the OYA Superintendent or designee will, if he/she has not already done so, appoint a qualified and independent person not directly involved with the offender, to cross-examine the witness for the offender. The hearing may be recessed if necessary for this purpose.

(D) The administrative commitment hearing may be continued with recesses as determined by the hearing officer.

(E) The hearing officer may set reasonable time limits for oral presentation and may exclude or limit cumulative, repetitious or immaterial evidence.

(F) The burden of presenting evidence to support a fact or position rests on the proponent of that fact or position. An offender may be administratively committed or the transfer extended only if the hearing officer finds by clear and convincing evidence that the offender is a mentally ill person as defined in ORS 426.005.

(G) Exhibits will be marked and the markings will identify the person offering the exhibit. The exhibits will be preserved by the OYA as part of the record of the proceedings.

(H) Evidentiary rules are as follows.

(i) Evidence of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs is admissible.

(ii) Irrelevant, immaterial, or unduly repetitious evidence will be excluded.

(iii) All offered evidence, not objected to, will be received by the hearing officer subject to his/her power to exclude irrelevant, immaterial, or unduly repetitious evidence.

(iv) Evidence objected to may be received by the hearing officer with rulings on its admissibility or exclusion to be made at the hearing or at the time a final order is issued.

(I) All testimony will be given under oath.

(J) The hearing officer may discontinue the commitment proceedings at any time and may return the offender to the OYA facility.

(7) The hearing officer will make a written summary of what occurs at the hearing, including the response of the offender and the substance of the documents or evidence given in support of administrative commitment.

(a) A mechanical recording of all oral testimony and presentations will be made. This tape may be reviewed by the hearing officer before any findings are determined, or in the event of a judicial review.

(b) Tapes will be kept at least 120 days after the final order is issued.

(8) The hearing officer will issue a written proposed order that contains:

(a) Rulings on admissibility of offered evidence and other matters;

(b) Findings of fact (each ultimate fact as determined by the hearing officer based on the evidence before it); and

(c) Conclusions and recommendations for action by the hearing officer.

(A) No Justification: The hearing officer may find that the evidence does not support placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by DHS, in which case the hearing officer will recommend that the offender return to his or her former status with all rights and privileges of that status. The hearing record will be processed with final action subject to review by the Director of DHS or designee. The findings must be on the merits. Technical or clerical errors in the writing or processing of the transfer request, or both, will not be grounds for a no justification finding, unless there is substantial prejudice to the offender.

(B) Justification: The hearing officer may find the evidence supports the offender's placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by DHS, in which case the hearing officer will so inform the offender and recommend that the offender's administrative commitment exceed 30 days. The hearing record will be processed with final action subject to review by the Director of DHS or designee. An offender's administrative commitment to a state mental hospital will not exceed 180 days unless the commitment is renewed in a subsequent administrative hearing in accordance with these rules.

(9) Hearing Record:

(a) Upon completion of a hearing, the hearing officer will prepare and cause to be delivered to the Director of DHS or designee a hearing record within three (3) days from the date of the hearing.

(b) The hearing record will include:

(A) Examination reports

(B) Notice of hearing and rights;

(C) Recording of hearing;

(D) Supporting material(s); and

(E) Findings of Fact, Conclusions, and Recommendation of the hearing officer.

(10) The results of any hearing held to place an offender in a state mental hospital for administrative commitment will be reviewed and approved by the Director of DHS or designee. The Director of DHS or designee will review the Findings-of-Fact, Conclusions, and Recommendation of the hearing officer, in terms of the following factors:

(a) Was there substantial compliance with this rule;

(b) Was the decision based on substantial information; and

(c) Was the decision proportionate to the information and consistent with the provisions of this rule.

(11) Within three (3) days of the receipt of the hearing officer's report, the Director of DHS or designee will enter an order, which may:

(a) Affirm the recommendation;

(b) Modify the recommendation;

(c) Reverse the recommendation; or

(d) Reopen the hearing for the introduction and consideration of additional evidence.

(12) When the Director of DHS or designee takes action to modify or reverse, he or she must state the reason(s) in writing and immediately notify the offender, hearing officer, and the Superintendent of the sending OYA facility.

(13) When the Director of DHS or designee reopens the hearing under this rule, the hearing officer will, pursuant to these rules, conduct the reopened hearing and prepare an amended hearing record within three (3) days of the reopened hearing. The Director of DHS or designee will review the hearing officer's recommendation and enter an amended order, which may affirm, modify, or reverse the hearing officer's recommendation.

(14) Extension of Transfer: If DHS determines that the administrative commitment must exceed 180 days in order to stabilize the offender; the administrative commitment must be renewed in a subsequent administrative commitment hearing held in accordance with these rules.

(15) Notwithstanding this rule, an administrative commitment may not continue beyond the term of legal custody to which the offender was sentenced.

Stat. Auth.: ORS 179.040, 179.473, 179.475, 420.500 & 420.505
Stats. Implemented: ORS 179.040, 179.473, 179.475, 420.500 & 420.505
Hist.: MHD 8-2005(Temp), f. & cert. ef. 7-15-05 thru 1-7-06; MHD 9-2005, f. 12-28-05, cert. ef. 1-1-06

Assignment and Transfer of Inmates

309-120-0200
Purpose

Purpose. These rules prescribe procedures by which inmates of Department of Corrections facilities may be transferred to a state mental hospital listed in ORS 426.010.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(1) and (2); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; MHD 7-2005(Temp), f. & cert. ef. 7-7-05 thru 1-3-06; Renumbered from 309-120-0000, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0205
Definitions

As used in these rules:

(1) "Department of Corrections Facility" means any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(2) "Inmate" means any person under the supervision of the Department of Corrections who is not on parole, probation, or post-prison supervision status.

(3) "Mentally Ill Inmate" means an inmate who, because of a mental disorder, is one or more of the following:

(a) Dangerous to self or others.

(b) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

(c) An inmate who:

(A) Is chronically mentally ill, as defined in ORS 426.495;

(B) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the Department of Human Services under ORS 426.060;

(C) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in subparagraph (3)(c)(B) of this rule; and

(D) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the inmate will become a person described under either or both subparagraph (3)(c)(A) or (3)(c)(B) of this rule.

(4) "State Mental Hospital" as defined in ORS 426.010. Except as otherwise ordered by the Department of Human Services pursuant to ORS 179.325, the Oregon State Hospital in Salem, Marion County, and the Blue Mountain Recovery Center in Pendleton, Umatilla County, shall be used as state hospitals for the care and treatment of mentally ill persons who are assigned to the care of such institutions by the Department of Human Services or who have previously been committed to such institutions.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(3); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; MHD 7-2005(Temp), f. & cert. ef. 7-7-05 thru 1-3-06; Renumbered from 309-120-0005, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0210
Administrative Transfers (Mentally Ill Inmates)

(l) The Administrator of the Department of Corrections Counseling and Treatment Services Unit/designee may request the Superintendent/designee of a state mental hospital listed in ORS 426.010 to accept a transfer of a mentally ill inmate to a state mental hospital pursuant to these rules.

(2) An inmate may be transferred to a state mental hospital for stabilization and evaluation for mental health treatment for a period not to exceed 30 days unless the transfer is extended pursuant to a hearing conducted in accordance with these rules.

(3) If space is available and the Superintendent/designee of the state mental hospital approves, the inmate shall be transferred.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0215
Hearings Process

(1) The Department of Human Services shall provide for an administrative commitment hearing conducted by a hearings officer employed or under contract with the Department of Corrections for administrative commitment or extension of the transfer of the inmate if:

(a) The Department of Human Services determines that administrative commitment for treatment for a mental illness is necessary or advisable or that the Department of Human Services needs more than 30 days to stabilize or evaluate the inmate; and

(b) The inmate does not consent to the administrative commitment or an extension of the transfer.

(c) Inmates in the legal custody of the Department of Corrections and in the physical custody of the Oregon Youth Authority (OYA) will be administratively committed through an OYA hearing, pursuant to OAR 416-425-0020. Inmates in OYA physical custody will be transferred directly from an OYA facility to a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Department of Human Services and returned directly to the OYA facility.

(2) It is the responsibility of the Superintendent/designee of the Oregon State Hospital to notify the hearings officer of the need for a hearing and to provide him or her with a transfer request containing the evidence justifying such action.

(3) The hearing shall be conducted by an independent hearing officer.

(4) The hearings officer shall not have participated in any previous way in the assessment process.

(5) The hearings officer may pose questions during the hearing.

(6) The evidence considered by the hearings officer will be of such reliability as would be considered by reasonable persons in the conduct of their serious affairs.

(7) When confidential informant testimony is submitted to the hearings officer, the identity of the informant and the verbatim statement of the informant shall be revealed to the hearings officer in writing, but shall remain confidential.

(8) In order for the hearings officer to rely on the testimony of a confidential informant, information must be submitted to the hearings officer from which the hearings officer can find that the informant is a person who can be believed or that the information provided in the case at issue is truthful.

(9) At the conclusion of the hearing, the hearings officer will deliberate and determine whether by clear and convincing evidence that the inmate is a mentally ill person as defined in ORS 426.005 and will be administratively committed involuntarily to a state mental hospital. The hearings officer may postpone the rendering of a decision for a reasonable period of time, not to exceed three (3) working days from the date of the hearing, for the purpose of reviewing the evidence.

(10) An inmate subject to an administrative commitment to a state mental hospital has the rights to which persons are entitled under ORS 179.485.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0220
Representation

(1) In all cases, the inmate is entitled to:

(a) Speak in his or her own behalf; and

(b) Be present at all stages of the hearings process, except when the hearings officer finds that to have the inmate present would present an immediate threat to facility security or safety of its staff or others. The reason(s) for the finding shall be part of the record.

(2) Assistance by a qualified and independent person approved by the hearings officer will be ordered upon a finding that assistance is necessary based upon the inmate's financial inability to provide an assistant, language barriers, or competence and capacity of the inmate to prepare a defense, to understand the proceedings, or to understand the rights available to him or her. An inmate subject to an administrative commitment hearing may not receive assistance from another inmate.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0225
Notice of Hearing

(1) The inmate shall be given written notice that an administrative commitment to a state mental hospital listed in ORS 426.010, a hospital or facility designated by the Department of Human Services, or an extension of the transfer is being considered by the Department of Corrections and the Department of Human Services.

(2) The notice will be provided by the hearings officer. Such notice must be provided far enough in advance of the hearing to permit the inmate to prepare for the hearing, but in no case shall notice be provided less than 24 hours prior to the hearing. The hearing shall take place no later than five (5) days from the date of service of the notice.

(3) The notice shall include a copy of this rule.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0230
Investigation

(1) The inmate may request that an investigation be conducted. If an investigation is ordered, a designee of the hearings officer shall conduct the investigation. No person shall serve as an investigator who has participated in any previous way in the process.

(2) An investigation shall be conducted upon the inmate's request, if an investigation will assist in the resolution of the proceedings and the information sought is within the ability of the facility to procure or the inmate to provide with his or her own resources.

(3) The hearings officer may order an investigation on his or her own motion.

(4) The hearings officer shall allow the inmate access to the results of the investigation unless disclosure of the investigative results would constitute a threat to the safety and security of the facility, its staff or others, or to the orderly operation of the facility.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0235
Documents/Reports

(1) An inmate may present documents or reports during the hearing, subject to the exclusion and restrictions provided in these rules.

(2) The reporting employee or other agents of the Department of Corrections or Department of Human Services who are knowledgeable may submit to the hearings officer documents or reports in advance of the hearing that are being relied upon for the administrative commitment or extension of the transfer. Such evidence must be disclosed to the inmate during the hearing.

(3) The hearings officer may exclude documents or other evidence upon finding that such evidence would not assist in the resolution of the proceeding, or that such evidence would present an undue risk to the safety, security, and orderly operation of the facility. The reason(s) for exclusion shall be made part of the record.

(4) Notwithstanding subsection (2) of this rule, the hearings officer may classify documents or other evidence as confidential, and not disclose such evidence to the inmate, upon finding that disclosure of psychiatric or psychological information would constitute a danger to another individual, compromise the privacy of a confidential source, or would constitute an immediate and grave detriment to the treatment of the individual, if medically contraindicated by the treating physician or a licensed health care professional in the written account of the inmate. The reason(s) for classifying documents or other evidence as confidential shall be made part of the record.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0240
Witnesses

(1) The hearings officer shall direct the scheduling and taking of testimony of witnesses at the hearing. Witnesses may include inmates, employees, or other persons. Testimony may be taken in person, by telephone, or by written report or statement.

(2) Except as provided in this subsection, a hearings officer must provide an inmate or his or her representative with the opportunity to call witnesses to testify before the hearings officer and to confront and cross-examine witnesses called by the state. The hearings officer may deny the opportunity provided in this rule upon a finding of good cause. Good cause includes, but is not limited to, an undue risk to the safety, security, or orderly operation of the facility or an immediate and grave detriment to the treatment of the individual due to disclosure of psychiatric or psychological information, if medically contraindicated by the treating physician or a licensed health care professional. The reason(s) for any denial of the opportunity to call witnesses or confront and cross-examine witnesses shall be made part of the record.

(3) If the inmate intends to call witnesses, the inmate must request that the hearings officer schedule witnesses to present testimony at the hearing. The request must be submitted to the hearings officer in writing in advance of the hearing, and include a list of the person(s) the inmate requests to be called to testify and direct examination questions to be posed to each person. The hearings officer shall arrange for the taking of testimony from such witnesses as properly requested by the inmate, subject to the exclusions and restrictions provided in these rules. The hearings officer, rather than the inmate, shall pose questions submitted by the inmate, including questions on cross-examination, if any. The hearings officer may briefly recess the hearing to allow the inmate, the inmate's assistant, or both, an opportunity to prepare cross-examination questions.

(4) The hearings officer may limit testimony when it is cumulative or irrelevant.

(5) All questions which may assist in the resolution of the proceedings, as determined by the hearings officer, shall be posed. The reason(s) for not posing a question will be made part of the record.

(6) The hearings officer may, on his or her own motion, call witnesses to testify.

(7) The hearings officer may exclude a specific inmate or staff witness upon finding that the witness' testimony would not assist in the resolution of the proceeding or presents an immediate undue hazard to facility security. If a witness is excluded, the reason(s) shall be made part of the record.

(8) The hearings officer may exclude other persons as witnesses, after giving reasonable consideration to alternatives available for obtaining witness testimony, upon finding that the witness' testimony would not assist the hearings officer in the resolution of the proceeding, the witness' appearance at the hearing would present an undue risk to the safety, security, or orderly operation of the facility or the safety of the witness or others, or that the witness is not reasonably available. The reason(s) for exclusion shall be made part of the record.

(9) Persons other than staff requested as witnesses may refuse to appear or testify.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0245
Postponement

(1) A hearing may be postponed by the hearings officer for good cause and for reasonable periods of time.

(2) Good cause includes, but is not limited to:

(a) Illness or unavailability of the inmate;

(b) Gathering of additional evidence; or

(c) Gathering of additional documentation.

(3) The reason(s) for the postponement shall be made part of the record.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0250
Findings

(1) No Justification: The hearings officer may find that the evidence does not support placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Department of Human Services, in which case the hearings officer will recommend that the inmate return to his or her former status with all rights and privileges of that status. The hearing record shall be processed with final action subject to review by the Superintendent/designee of the Oregon State Hospital. The findings must be on the merits. Technical or clerical errors in the writing or processing of the transfer request, or both, shall not be grounds for a no justification finding, unless there is substantial prejudice to the inmate.

(2) Justification: The hearings officer may find the evidence supports the inmate's placement in a state mental hospital listed in ORS 426.010 or a hospital or facility designated by the Department of Human Services, in which case the hearings officer will so inform the inmate and recommend that the inmate's administrative commitment exceed 30 days. The hearing record shall be processed with final action subject to review by the Superintendent/designee of the Oregon State Hospital. An inmate's administrative commitment to a state mental hospital shall not exceed 180 days unless the commitment is renewed in a subsequent administrative hearing in accordance with these rules.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0255
Hearing Record

(1) Upon completion of a hearing, the hearings officer shall prepare and cause to be delivered to the Superintendent/designee of the Oregon State Hospital a hearing record within three (3) days from the date of the hearing.

(2) The record of the formal hearing shall include:

(a) Examination reports;

(b) Notice of hearing and rights;

(c) Recording of hearing;

(d) Supporting material(s); and

(e) "Findings-of-Facts, Conclusions, and Recommendation" of the hearings officer.

(3) The hearings officer will retain the recording and forward to the Superintendent/designee of the Oregon State Hospital items (2)(a), (2)(b), (2)(d), and (2)(e) of this rule.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0260
Superintendent's Review

(1) The results of any hearing held to place an inmate in a state mental hospital for administrative commitment will be reviewed and approved by the Superintendent/designee of the Oregon State Hospital.

(2) The Superintendent/designee of the Oregon State Hospital shall review the "Findings-of-Fact, Conclusions, and Recommendation" of the hearings officer, in terms of the following factors:

(a) Was there substantial compliance with this rule;

(b) Was the decision based on substantial information; and

(c) Was the decision proportionate to the information and consistent with the provisions of this rule.

(3) Within three (3) days of the receipt of the hearings officer's report, the Superintendent/designee of the Oregon State Hospital shall enter an "order," which may:

(a) Affirm the recommendation;

(b) Modify the recommendation;

(c) Reverse the recommendation; or

(d) Reopen the hearing for the introduction and consideration of additional evidence.

(4) When the Superintendent/designee of the Oregon State Hospital takes action to modify or reverse, he or she must state the reason(s) in writing and immediately notify the inmate, hearings officer, and Administrator for Counseling and Treatment Services.

(5) When the Superintendent/designee of the Oregon State Hospital reopens the hearing under this rule, the hearings officer shall, pursuant to these rules, conduct the reopened hearing and prepare an amended hearing record within three (3) days of the reopened hearing. The Superintendent/designee of the Oregon State Hospital shall review the hearing officer's recommendation and enter an amended "order," which may affirm, modify, or reverse the hearing officer's recommendation.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0265
Extension of Transfer

(1) If the Department of Human Services determines that the administrative commitment must exceed 180 days in order to stabilize the inmate, the administrative commitment must be renewed in a subsequent administrative commitment hearing held in accordance with these rules.

(2) Notwithstanding this rule, an administrative commitment may not continue beyond the term of incarceration to which the inmate was sentenced.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0270
Handling of Inmate Money and Personal Property

(1) When an inmate is transferred to a state mental hospital, the Department of Corrections shall send a check for the balance of the inmate's account to the business office of the state mental hospital.

(2) The inmate's personal property will be transferred from the Department of Corrections facility in accordance with standards and limitations set by the state mental hospital to which the inmate is transferred.

(3) When the inmate is returned to a Department of Corrections facility, the inmate's money and personal property, as allowed by the Department of Corrections Rules for Personal Property (Inmate) (OAR 291-117) and Trust Accounts (Inmate) (OAR 291-158), will be returned with the inmate. All property not allowed under the Department of Corrections rules for Personal Property (Inmate) shall be handled, controlled and disposed of in accordance with Department of Human Services rules (OAR 309-108-0000 through 309-108-0020).

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(5); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0030, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0275
Visiting Privileges

(1) When an inmate is transferred to a state mental hospital, the Department of Corrections facility shall provide a copy of the inmate's approved list of visitors.

(2) All visitors shall be approved according to the state mental hospital's procedure.

(3) When an inmate is returned to a Department of Corrections facility, any new names added to the list will be subject to review and approval according to the Department of Corrections Rule on Visiting (Inmate) (OAR 291-127) before admission of new visitors will be allowed.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(5); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0035, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0280
Short-Term Transitional Leaves, Emergency Leaves and Supervised Trips

When an inmate is administratively transferred to a state mental hospital, no short-term transitional leaves, emergency leaves, or supervised trips shall be approved by the state mental hospital without approval of the functional unit manager of the Department of Corrections facility.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(6); MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0040, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0285
Releases from a State Mental Hospital

An inmate who is transferred to a state mental hospital may be discharged and transferred back to a Department of Corrections facility for one of the following reasons:

(1) Completion of treatment;

(2) He/she could receive mental health services within the Department of Corrections, and there was a mutually agreed upon continuity of care plan developed by the state mental hospital and the Administrator of the Department of Corrections Counseling and Treatment Services Unit/designee; or

(3) He/she does not meet the requirements to continue treatment at a state mental hospital.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(7); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0045, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0290
Reporting of Unusual Incidents

Reporting of unusual incidents involving inmates administratively transferred to a state mental hospital shall be handled in accordance with the Department of Corrections policy on Unusual Incident Reporting Process.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(8); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0050, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06

309-120-0295
Confidentiality and Sharing of Information

(1) Department of Corrections records and other inmate information shall not be available to inmates or persons not employed by, nor under contract to, the Department of Human Services.

(2) Department of Human Services records and information will be handled in accordance with ORS 179.495, 179.505, 192.501, 192.502, 192.505 and 42 CFR Part 2 relating to confidentiality of medical treatment records.

Stat. Auth.: ORS 179.040, 179.473, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439.
Stats. Implemented: ORS 179.040, 179.473, 179.475, 179.478, 179.479, 179.495, 179.505, 2005 OL, Ch. 439
Hist.: MHD 43, f. & ef. 11-5-76; MHD 5-1979, f. & ef. 8-14-79; MHD 12-1979(Temp), f. & ef. 11-21-79; MHD 3-1980, f. & ef. 4-1-80; MHD 1-1981, f. & ef. 6-5-81; MHD 1-1983(Temp), f. & ef. 1-5-83; MHD 8-1983, f. & ef. 4-1-83, Renumbered from 309-023-0010(9); MHD 3-1995, f. & cert. ef. 4-13-95; MHD 1-2000, f. & cert. ef. 1-24-00; Renumbered from 309-120-0055, MHD 10-2005, f. 12-29-05, cert. ef. 1-1-06