Kent Taylor Civic Hall
200 NE Second Street
McMinnville, OR 97128

Special Called City Council Meeting Agenda
Wednesday, March 20, 2019
5:30 PM

1. Call to Order
2. Update on Residential Support Facility (Care Facility) Ordinance
3. Adjournment

Kent Taylor Civic Hall is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made a least 48 hours before the meeting to the City Recorder (503) 435-5702 or melissa.bisset@mcminnvilleoregon.gov.

City of McMinnville
Fire Department
175 NE 1st Street
McMinnville, OR 97128
(503) 435-5800
www.mcminnvilleoregon.gov

STAFF REPORT

DATE: **March 20, 2019**
TO: **Mayor and City Councilors**
FROM: **Rich Leipfert, Fire Chief**
SUBJECT: **UPDATE: Residential Support Facility (Care Facility) Ordinance**
STRATEGIC PRIORITY & GOAL:

COMMUNITY SAFETY & RESILIENCY
Proactively plan for & responsively maintain a safe & resilient community.

OBJECTIVE/S: Provide exceptional police, municipal court, fire, emergency medical services EMS), utility services and public works

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Report in Brief: The purpose of the work session will be to review the implementation of the City's specialty business license program for Residential Support Facilities (care facilities) and discuss proposed revisions to improve the program.

Background: On October 9, 2018, the City Council adopted ordinance 5059, which established a specialty business license program for care facilities for the purpose of providing adequate levels of oversight to ensure that the special health, safety and welfare needs of facility residents were protected. In addition, the ordinance established requirements that residential support facilities employ sufficient staff to meet the nonemergency care needs of their residents without reliance on the City's EMS system, and authorizing a fee for the City to provide such nonemergency care services.

Discussion: Following the adoption and implementation of the program, we have monitored the effectiveness of the program and have considered feedback from stakeholders regarding various provisions of the ordinance. In addition, staff has continued to monitor regulatory activities in Oregon and other states related to the challenges in protecting vulnerable residents of these facilities.

The purpose of the work session is to present updated information to the Council on these subjects. In addition, staff will present a draft ordinance to update and revise the specialty business license program for residential care facilities, in order to improve the City's ability to achieve its goals of protecting the health, safety and welfare needs of facility residents.

Chapter 5.40

Residential Support Facilities

Contents

5.40.105 Definitions.

A. "**Activities of Daily Living**" or "**ADL**" means those personal functional activities required by a resident for continued well-being and are essential for health and safety, mobility, receiving prescribed medications, accessing transportation for nonemergency medical appointments or procedures, and receiving nonemergency medical care at the facility.

B. "**Ambulance**" means a motor vehicle owned or operated by the City that is regularly provided or offered to be provided for the emergency or nonemergency medical transportation of persons who are ill or injured or who have disabilities.

C. "**Assisted Living Facility**" or "ALF" means an assisted living facility as defined by OAR 411-054-0005.

D. "**Change of Condition – Short-Term**" means a change in the resident's health or functioning, that is expected to resolve or be reversed with minimal intervention, or is an established, predictable, cyclical pattern associated with a previously diagnosed condition.

E. "**Change in Condition – Significant**" means a major deviation from the most recent evaluation, that may affect multiple areas of functioning or health, that is not expected to be short-term, and imposes risk to the resident. Examples or significant change of condition include, but are not limited to:
   1) Broken bones.
   2) Stroke, heart attack, or acute illness or condition onset.
   3) Unmanaged high blood sugar levels.
   4) Uncontrolled pain.
   5) Fast decline in activities of daily living.
   6) Significant unplanned weight loss.
   7) Pattern of refusing to eat.
   8) Level of consciousness change.
   9) Pressure ulcers (stage 2 or greater).

F. "**Department**" means the Oregon Department of Human Services.

G. "**Direct Care Staff**" means an individual employed by or working under contract for a licensee and whose primary responsibility is to provide personal care to residents, including:
   1) Medication administration;
   2) Assistance with activities of daily living; and
   3) Supervision and support of residents.

H. "**Disaster**" means a disruption to normal care and services caused by an unforeseen occurrence beyond the control of the licensee whether natural, technological or manmade, and that threatens the safety of residents. Disasters include:
   1) Fire, smoke, bomb threat or explosion;
   2) Prolonged power failure, water, or sewer loss;
   3) Structural damage to a Facility;
   4) Hurricane, tornado, tsunami, volcanic eruption, flood, and earthquake;
   5) Chemical spill or leak;
   6) Pandemic; and
   7) Similar unforeseen occurrence.

I. "**Disaster Preparedness Plan**" means a written plan that identifies a facility's response to a disaster for the purpose of minimizing loss of life, mitigating trauma, and to the extent possible, maintaining support services for residents.

J. "**Emergency call**" means a request for assistance using any device capable of direct communication to the 9-1-1 emergency reporting system in which prompt service is essential to preserve human life through the application of emergency care.

K. "**Emergency Care**" means the performance of medical care under emergency conditions in the observation, care and counsel of residents who are ill or injured or who have disabilities, including medical care provided to a resident that has experienced a significant change of condition;

L. "**Emergency Medical Service**" or "**EMS**" means emergency care and emergency medical transportation services provided by the City to persons who are ill or injured or have disabilities.

M. "**Emergency Medical Transportation**" means the transportation of a resident who is ill or injured or who has a disability, and who requires the administration of emergency care, to a hospital in an ambulance.

N. "**Facility Administrator**" or "**Administrator**" means an individual employed by a facility that has authority to ensure that the facility is operated in full compliance with the provisions of this Chapter.

O. "**Fire Code**" means the provisions of MMC Chapter 15.08 together with the provisions of the Oregon fire code adopted by the State of Oregon pursuant to Oregon Administrative Rules Chapter 837, Division 40, including all designated provisions of the Oregon Structural Specialty Code and the Oregon Mechanical Specialty Code.

P. "**Licensee**" means any person to whom a specialty business license has been issued under the provisions of this Chapter, and include such person's employees, contractors, agents and assigns.

Q. "**Medical Care**" means the observation, care or counsel of a resident, including but not limited to the administration of medications prescribed by a physician licensed under ORS chapters 677 or 685, insofar as any of those acts are based upon knowledge and application of the principles of biological, physical and social science.

R. "**Nonemergency Care**" means the performance of medical care on a resident who is not expected to die, become permanently disabled or suffer permanent harm within the next 24 hours, including but not limited to medical care for a resident that has experienced a short-term change of condition.

S. "**Nursing Care**" or "**Nursing Services**" means direct and indirect care provided by a registered nurse, licensed practical nurse, or nursing assistance.

T. "**Person**" means an entity including an individual, a trust, an estate, a partnership, or a corporation, including associations, joint stock companies, and insurance companies, that operates a Facility.

U. "**Resident**" means any individual who:
   1) has been admitted to, but not discharged from, a skilled nursing facility or,
   2) is receiving room, board, care, and services on a 24-hour basis in an assisted living facility or residential care facility.

V. "**Residential Care Facility**" or "**RCF"** means a residential care facility as defined by OAR 411-054-0005.

W. "**Residential Support Facility**" or "**Facility**" means:
   1) An assisted living facility;
   2) A residential care facility; or
   3) A skilled nursing facility.

X. "**Retaliate**" means to threaten, intimidate, or take action that is detrimental to a resident, including but not limited to:
   1) Increasing charges or decreasing services, rights or privileges;
   2) Threatening to increase charges or decrease services, rights or privileges;
   3) Taking or threatening any action to coerce or compel the resident to leave the facility; or,
   4) Abusing, harassing or threatening to abuse or harass a resident.

Y. "**Safety**" or "**Personal Safety**" means the condition of being protected from environmental hazards or disasters.

Z. "**Skilled nursing facility**" or "**SNF**" means a nursing facility as defined by OAR 411-057-0005.

AA. "**Support Services**" means supervision or assistance provided in support of a resident's personal needs, preferences or comfort, and related to the resident's personal safety, nonemergency medical care and activities of daily living.

BB. "**Unit**" means:
   1) a room in a skilled nursing facility; or,
   2) the personal and sleeping space of a resident at an assisted living facility or residential care facility.

CC. "**9-1-1 emergency reporting system**" means a telephone service that provides the users of a public telephone system the ability to request emergency medical services by calling 9-1-1.

5.40.110 Specialty business license required.

A. A person must obtain a specialty business license in accordance with the provisions of this Chapter prior to operating any residential support facility within the city.
B. If any person operates a more than one facility in the city, the person must obtain a separate license for each distinct facility; however, separate licenses are not required for separate buildings located contiguously and operated as an integrated unit by the same ownership or management.
C. Any person operating a facility on the effective date of this Ordinance and that does not already have a specialty business license issued by the City must apply for a license within 60 days of the effective date of this Ordinance.
D. Any person that advertises or otherwise holds themselves out to the public as operating a residential support facility will be conclusively presumed as operating such a facility, and must comply with the provisions of this Chapter.
E. The city manager or designee may adopt and enforce all policies, regulations and procedures deemed prudent and necessary to implement the provisions of this chapter.

5.40.115 Application for license; Issuance; Expiration.

A. Application for the license required by this chapter must be made upon forms and in the manner provided by the city on or before the first day of January of each year for which a license is required.
B. The City will review all applications within 10 business days of receipt to determine whether the application is complete. If the City determines that the application is incomplete, the City will notify the applicant of that determination in writing. Incomplete applications will expire if not completed within 90 days. In the event a license application expires, the application fee will be forfeited.
C. The City will review any completed application and, if it complies with all requirements of this chapter, the City will issue a specialty business license within 30 days of its determination that the application is complete.
D. Each license is issued for a calendar year and expires at midnight on December 31, unless revoked or terminated earlier, or issued for a shorter specified period.
E. The issuing of a license pursuant to this chapter or the collection of a fee or tax does not authorize any person to operate a facility in violation of any other law or regulation.

5.40.120 Examination of business premises; Administrative hearing.

A. The city manager is directed and empowered to authorize city officials and agents to investigate and examine all facilities subject to license under the terms of this chapter at any time and all reasonable times for the purpose of determining whether such facility is operated in compliance with the provisions of this Chapter.
B. In addition to the other provisions of this Chapter, the following City rules and regulations must be met, unless it is determined by the City that such requirements are not applicable to the facility:
    1) Health and safety codes set forth in MMC Title 8;
    2) Building and construction codes set forth in MMC Title 15; and,
    3) Land use regulations set forth in MMC Title 17 and other land use ordinances adopted by the City, including the City's acknowledged comprehensive plan and zoning code.

5.40.125 Inspections and Investigations

A. Licensee must cooperate with City personnel in inspections, investigations, planning for resident safety, application procedures, and other activities necessary to ensure compliance with the provisions of this Chapter.
   1) Licensee must provide the City access to all resident and facility records necessary to carry out or enforce the provisions of this Chapter, and such records must be made available to the City upon request.
   2) Licensee must allow City to conduct private interviews with residents for the purpose investigating complaints or otherwise inspecting licensee's compliance with the provisions of this Chapter.

B. City will visit and inspect every facility at least, but not limited to, once every year to determine whether the facility is maintained and operated in accordance with the provisions of this Chapter.
   1) If the City determines that a licensee is not in compliance with the provisions of this Chapter, licensee must submit a plan of correction that satisfies the City within 10 days of receipt of the inspection report.
   2) The City may impose sanctions, license conditions, or take any other action described in this Chapter for failure to comply with provisions of this Chapter.

C. A copy of the most current inspection report and any conditions placed upon the license must be posted with the facility's license.

5.40.130 Display of license, notices.

A. Licensee must openly display all licenses issued in accordance with this chapter in the facility and must immediately produce and deliver such license for inspection to the City manager or designee, when so requested.

B. The location for display of the license and any notice required to be posted this Chapter must be in an area that:
   1) Is routinely accessible and conspicuous to Residents and visitors, including those in wheelchairs; and,
   2) Provides sufficient space for prominent conspicuous display of each notice.

5.40.135 Change of Ownership or Operator

A. When a change of ownership or change in operator is contemplated, both the licensee and prospective licensee must notify the City in writing of the contemplated change. The notice of change of ownership or operator must be received by the City at least 45 days prior to the proposed date of transfer. A shorter timeframe may be allowed at the sole discretion of the City. The notice of change of ownership or operator must be in writing and must include the following:
   1) Name and signature of the current licensee;
   2) The name of the prospective licensee;
   3) The proposed date of transfer; and,
   4) A complete signed specialty business license application from the prospective licensee.

B. A prospective licensee is responsible for the operation of the facility in compliance with the provisions of this Chapter until a new license is issued to a new owner or operator or the facility operation is terminated.

5.40.140 Facility Closure

A. Licensee must notify the City of the intent to close a facility 90 days prior to the anticipated date of closure.
B. Licensee is responsible for the operation of the facility in compliance with the provisions of this Chapter until all residents are transferred and the facility is closed.
C. Licensee must submit its Department-approved facility closure plan to the City 45 days prior to the anticipated date of closure. The closure plan must include:
    1) A description of operations during the closure period;
    2) The plan to assure adequate staff, supplies and services necessary to operate the facility in compliance with the provisions of this Chapter;
    3) The primary contact responsible for daily facility operations during the closure period;
    4) The Department-approved estimated date of closure; and,
    5) The address where the licensee may be reached by the City following facility closure.
D. Upon request, the licensee must provide the City with any additional information related to facility operations during the closure period.
E. The license will expire on the last day of facility operations, if facility operations are discontinued for any reason prior to December 31.

5.40.205 Facility Staffing, Orientation and Training

A. Licensee must ensure that the facility is under the supervision of a full time facility administrator. Upon termination of the administrator, the licensee must immediately replace the administrator with a full-time administrator. The licensee must notify the City within 7 days from the date that an administrator leaves employment of the facility, or any time that an administrator is expected to absent from the facility for a period of more than 14 days. Such notice must include the name and contact information for the new administrator or, in the event of a temporary absence, the temporary acting administrator.
B. Licensee must ensure that each employee, temporary employee, and volunteer completes an orientation program sufficient to ensure that the safety of all residents is assured in accordance with Facility policies, and the provisions of this Chapter. Orientation must be completed not later than 30 days following the start of employment or volunteer service, and before the employee or volunteer is placed in a position of independently responding to any event that threatens the safety of a resident.
C. Licensee must provide in-service training to ensure that all direct care staff and other employees are capable of responding appropriately to disasters or other events that threaten the safety of residents. Such training must address, at a minimum, the facility's:
    1) Disaster procedures, including but not limited to, the facility's disaster preparedness plan;
    2) Procedures for responding to life-threatening situations; and,
    3) Policies and practices relating to resident safety and accident prevention.
D. Licensee must document all orientation and in-service training, to include the date, content, and names of attendees.

5.40.210 Disaster Planning

A. Licensee must prepare and maintain a written disaster preparedness plan (also known as an emergency preparedness plan) in accordance with the fire code.
B. The disaster preparedness plan must include analysis and response to potential disasters, including:
    1) the policy and procedures to be followed related to the evacuation of the facility; and,

2) the plan for continuing to provide support services to residents during a disaster event.

C. Licensee must notify the City of the status of the facility and its residents in the event of any disaster that requires evacuation and during any emergent situation when requested.

D. Licensee must conduct a drill of the disaster preparedness plan at least twice a year. One of the practice drills may consist of a walk-through of the duties or a discussion exercise with a hypothetical event, commonly known as a tabletop exercise. These simulated drills must not take the place of the required fire drills, orientation or in-service training required by the provisions of this Chapter.

E. Licensee must annually review or update the disaster preparedness plan and the plan must be available for on-site review upon request by a resident or the City.

F. Licensee must submit the disaster preparedness plan to the City annually and within 30 days of any change of owner of operator.

5.40.215 Fire and Life Safety; Required Notification

A. Licensee must conduct periodic fire drills according to the fire code, meeting the following requirements:
   1) Unannounced fire drills must be conducted and recorded every other month at different times of the day, evening and night shifts.
   2) Fire and life safety instruction must be provided to staff on alternate months.
   3) The fire chief or designee may develop an alternate fire drill plan for the facility.
   4) A written fire drill record must be kept to document fire drills, to include:
      a) Date and time of day;
      b) Location of simulated fire origin;
      c) The escape route used;
      d) Problems encountered and comments relating to residents who resisted or failed to participate in drills;
      e) Evacuation time period needed;
      f) Staff members on duty and participating; and,
      g) Number of occupants (residents, staff and visitors) evacuated.
   5) Alternate exit routes must be used during fire drills to react to varying potential fire origin points.
   6) The evacuation capability of residents and staff is a function of both the ability of the residents to evacuate and the assistance provided by staff. Staff must provide fire evacuation assistance to residents to a designated point of safety in order to meet the evacuation standard established for the facility by the fire chief.
   7) The fire alarms system must be activated during each fire drill, unless otherwise directed by the fire chief or designee

B. If licensee is unable to meet the evacuation standard described in this section, they must make an immediate effort to make changes to ensure that the evacuation standard is met. If licensee fails to meet the applicable evacuation standard after making necessary changes, the City may initiate action to suspend or revoke the facility's license. Changes may include, but not be limited to:
   1) Increasing staff levels;
   2) Changing staff assignments;
   3) Requesting change in resident rooms;
   4) Arranging for special equipment; or,
   5) Any other changes necessary to meet the applicable standard.

C. Licensee must ensure that all fire detection systems, suppression systems, and sprinkler systems are installed and maintained in accordance with the fire code. Licensee must notify the City and obtain all required permits not less than 14 days prior to performing any major repairs, rehabilitation or replacement of such systems.
D. Licensee must develop and implement a safety program to mitigate and eliminate hazards to residents such as:
    1) Dangerous substances;
    2) Sharp objects;
    3) Unprotected electrical outlets;
    4) Slippery floors or stairs;
    5) Exposed heating devices;
    6) Broken glass;
    7) Water temperatures; and,
    8) Fire prevention.
E. Licensee must instruct residents about the facility's fire and life safety procedures, as follows:
    1) Instruction must be provided as required by the fire codes;
    2) Within 24 hours of admission, and annually, each resident must be instructed in general safety procedures, evacuation methods, responsibilities during fire drills, and designated meeting places outside the building or within the safe area in the event of an actual fire. This requirement does not apply to residents whose mental capacity does not allow for following such instruction.
    3) A written record of fire safety training for residents, including content of the training session, must be kept.
F. Licensee must ensure that:
    1) Stairways, halls, doorways, passageways, and exits from rooms and the building remain unobstructed.
    2) First aid supplies are provided, properly labeled, and readily accessible.
G. Licensee must notify the fire chief or designee within 72 hours of:
    1) The accidental or unusual death of a resident;
    2) Any situation in which the health or safety of a resident was or is endangered as a result of fire or any other disaster; or,
    3) Any incident in which the licensee's failure to comply with any provision of this Chapter has caused, or is reasonably likely to cause, a resident:
        a) Serious injury;
        b) Serious harm;
        c) Serious impairment; or,
        d) Death.

5.40.220 Support Services and Nonemergency Care Services

A. Licensee must designate one or more employees that are responsible for coordinating the support services for residents. Such employees must have authority to ensure that the facility's direct care staff provide adequate support services on a 24-hour basis to:
    1) Assist residents in performing ADL's;
    2) Assist residents with mobility, including lift assists and transfers;
    3) Meet the resident's nonemergency medical service and medication administration needs;
    4) Assess a resident's change of condition as either short term or significant and direct an appropriate treatment plan; and,

5) Arrange for a resident's transportation for nonemergency medical purposes, ancillary services for medically related care (e.g. physician, pharmacist, therapy, podiatry, hospice or home health) and other health-related services to support the Resident.

B. Licensee must have written policies to ensure a resident monitoring system is implemented 24-hours a day. The policies must specify staff responsibilities and identify criteria for notifying the support services coordinator and for activating the 9-1-1 emergency reporting system. Licensee must:
   1) Monitor each resident consistent with their evaluated needs and service plan;
   2) Train direct care staff to identify changes in the resident's physical, emotional and mental functioning and document and report on the resident's changes of condition;
   3) Have a reporting protocol with access to a designated staff person, 24-hours a day, seven days a week, who can determine if a change in the resident's condition requires action, including but not limited to placement of an emergency call; and,
   4) Provide written communication of a resident's change of condition, and any required interventions, for direct care staff of each shift.

C. Licensee must provide health services and have a system in place to respond to the 24-hour care needs of residents. The system must:
   1) Include written policies and procedures on medical emergency response for all shifts;
   2) Include an Oregon licensed nurse who is regularly scheduled for onsite duties at the facility and who is available for phone consultation by direct care staff;
   3) Assure an adequate number of nursing hours relevant to census and acuity of the resident population to provide nonemergency care; and,
   4) Define the duties, responsibilities and limitations of the facility nurse in policy and procedures, admission and disclosure material.

D. Licensee must coordinate on-site health services with outside service providers such as hospice, home health, or other privately paid supplemental health care providers, and must assist residents in accessing health care services and benefits to which they are entitled from outside providers.

E. Licensee must coordinate off-site health services for residents who cannot or choose not to self-manage their health services, by:
   1) Assisting residents to coordinate appointments with outside providers that are necessary to support the resident's needs; and,
   2) Arranging or providing transportation to residents for medical purposes.

F. Licensee must ensure that the support services described by this Section are provided in all nonemergency care situations by the facility's direct care staff without activation of the 9-1-1 emergency reporting system or reliance on the City's EMS system.

5.40.225 Resident Rights; Notice

A. Licensee must protect, encourage and assist residents in exercising the rights identified in this Chapter including, but not limited to, the right to:
   1) Receive support services from facility staff trained to provide nonemergency care that is specific to the resident's needs and without reliance on the City's EMS system.
   2) Receive support services from licensee without distinction, discrimination or restriction based on a resident's or their visitor's race, color, national origin, immigration or refugee status, religion, sex, gender identity (including gender expression), sexual orientation, age, economic status, or the resident's or visitor's mental, emotional or physical ability.
   3) Refuse to be transported by ambulance for any purpose other than emergency medical transportation.

4) Independently contact the 9-1-1 emergency reporting system when the resident reasonably believes that they are in need of emergency medical services.
5) Report violations of the provisions of this Chapter to the City for investigation or enforcement action.

B. Licensee must not retaliate against any resident after the resident, or the resident's legal representative, has exercised rights provided by law or rule (including the provisions of this Chapter) or has expressed an intention to exercise such rights.
C. Licensee must make reasonable accommodations in order to provide support services and access to all residents and visitors.
D. Licensee must provide written information to residents annually specifying alternative forms of transportation available to the resident for routine and nonemergency medical transportation, including information on the possible cost and how to access such service.
E. Licensee must provide written notice of residents' rights under the provisions of this Chapter within 24-hours of check-in and annually, on forms approved by the City.

5.40.305 Specialty Business License fees.

A. All persons, upon submittal of an initial application for a care facility specialty business license, must pay an application fee.
B. Prior to issuance of an initial residential support facility specialty business license and prior to each subsequent annual license renewal, a person must pay the specialty business license fee to the city. The fee will be calculated for each facility based upon the number of units operated by the facility. The cost of the application and specialty business license fees will be established by resolution of the city council.
C. The specialty business license fee will be prorated for any facility that commences operations after January 1, but will not be refunded for any license that terminates prior to December 31.
D. The fees imposed by this chapter are in addition to the general ad valorem taxes now or hereafter levied pursuant to law. All ordinances of the city in force on the effective date of the ordinance codified in this chapter pertaining to or covering any business, pursuit or occupation and providing a license or condition for its operation remain in full force and effect to the extent not directly in conflict with the provisions of this chapter.
E. All monies received from a specialty business license issued under this chapter will be deposited in the general fund for the purpose of supporting the city's building code, fire code, and emergency management operations.
F. No transfer or assignment of any license issued hereunder is valid or permitted, except as expressly allowed by the provisions of this Chapter.
G. In the event the applicable classification or fees assessable to a business require clarification or interpretation, any interested person may request a determination by the city manager, whose decision will be final. The city manager is authorized to waive all or a portion of established fees to meet the intent and purpose of this chapter.

5.40.310 Nonemergency Care Fees.

A. Licensee is encouraged to use the 9-1-1 emergency reporting system to request dispatch of the City's EMS employees during any situation where an individual, including a resident, is in need of emergency care or emergency medical transportation. Licensee should not use the 9-1-1 emergency reporting system to request assistance in providing only support services, including nonemergency care, to residents.

B. If the City determines that a licensee has used the 9-1-1 emergency reporting system for the primary purpose of requesting assistance in providing support services to a resident, the licensee may be assessed a nonemergency care fee. The cost of the nonemergency care fee will be established by resolution of the city council.
C. Examples of requests for EMS assistance that might result in the assessment of a nonemergency care fee include requests by licensee:
    1) To assist a resident that has fallen, is not injured, and has not requested that an EMS provider be called for assistance.
    2) To evaluate a resident that has experienced a short-term change of condition.
    3) To perform a lift assist or transfer of a resident that does not require emergency care.
    4) To assist a resident to renew a prescription or transport a resident to a hospital because the licensee has failed to assist the resident in renewing a prescription in a timely manner.
    5) To start an IV, replace a Foley catheter, perform wound care, or provide any other medical procedure when such care does not meet the definition emergency care.
    6) To provide transportation of a resident for any purpose other than emergency medical transportation.
D. The initial determination regarding whether to assess a nonemergency care fee pursuant to this Section will be made by the fire chief or designee. In making the determination, the City may, as appropriate:
    1) Review the medical charts and other reports from the call;
    2) Contact care home to interview direct care staff, other employees or residents regarding the call; and,
    3) Contact the Hospital to determine the existence and extent of any illness or injury suffered by the resident.
E. All monies received from the nonemergency care fee will be deposited in the ambulance fund for the purpose of supporting the City's EMS operations.
F. Licensee is prohibited from seeking reimbursement from or charging a fee to a resident for the purpose of recouping any portion of a nonemergency care fee assessed against licensee.
G. Licensee is prohibited from retaliating against a resident in response to being assessed a nonemergency care fee by the City.

5.40.315 Collection Charges; Interest and Penalties.

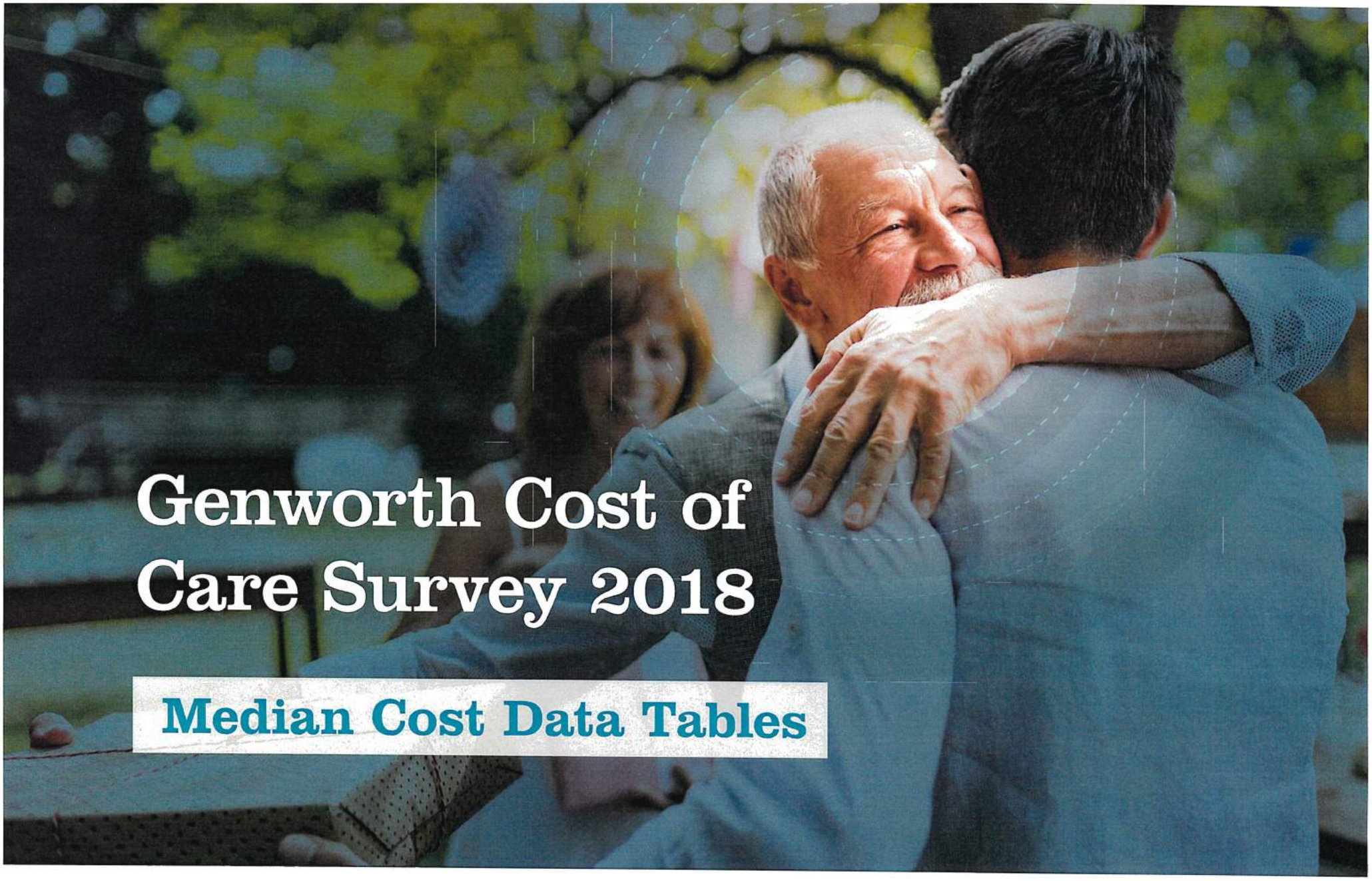
A. Penalties and fees imposed under the provisions of this Chapter must be paid within 30 days of the date of invoicing by the City, or they will be deemed delinquent. An initial collection charge equal to two percent (2%) of unpaid license fees or five percent (5%) of any other fee or penalty, will be imposed for fees and penalties that are delinquent for more than 30 days after the due date. Interest at the rate of one-percent (1%) per month or fraction of a month without proration for potions of a month, will be imposed on any unpaid fees from the due date until payment is received in full by the City. The city manager is authorized to waive payment of collection fees and interest under circumstances where imposition thereof would create an injustice or unreasonable hardship.
B. If the City determines that any person has failed to pay any fees imposed under the provisions of this Chapter due to fraud or intent to evade the provisions of this Chapter, a penalty of twenty-five-percent (25%) of the amount of the unpaid fees will be added, in addition to the collection charges and interest described in this section. The amount of any penalty assessed must be paid within 30 days of the date of invoicing by the City, or they will be deemed delinquent and subject to the additional collection charges and interest as described in this Section.

5.40.350 Penalties and Enforcement

RESERVED FOR DISCUSSION WITH COUNCIL

5.40.360 Administrative Hearings and Appeals

RESERVED FOR DISCUSSION WITH COUNCIL



Genworth Cost of Care Survey 2018

Median Cost Data Tables

282102 10/09/18

Genworth®

Annual Median Costs

	Home Health Care				Adult Day Health Care		Assisted Living Facility*		Nursing Home Care			
LOCATION	HOMEMAKER SERVICES[1]	5-YEAR ANNUAL GROWTH[2]	HOME HEALTH AIDE[1]	5-YEAR ANNUAL GROWTH[2]	ADULT DAY HEALTH CARE[3]	5-YEAR ANNUAL GROWTH[2]	PRIVATE, ONE BEDROOM[4]	5-YEAR ANNUAL GROWTH[2]	SEMI-PRIVATE ROOM[5]	5-YEAR ANNUAL GROWTH[2]	PRIVATE ROOM[5]	5-YEAR ANNUAL GROWTH[2]
USA – National	$48,048	2.85%	$50,336	2.51%	$18,720	2.07%	$48,000	3.00%	$89,297	3.44%	$100,375	3.64%
Alaska	$59,488	1.20%	$61,776	1.96%	$27,373	-1.42%	$75,600	0.98%	$351,495	5.35%	$330,873	5.27%
Alabama	$38,896	1.22%	$38,896	1.22%	$9,100	6.96%	$39,252	4.70%	$75,347	2.78%	$79,935	2.82%
Arkansas	$41,184	1.15%	$43,312	2.17%	$20,800	4.56%	$36,443	1.17%	$64,240	3.25%	$71,832	3.59%
Arizona	$52,052	3.67%	$53,196	3.06%	$24,050	4.28%	$45,600	2.55%	$77,928	1.42%	$94,900	1.87%
California	$59,488	3.40%	$59,488	2.53%	$20,150	0.13%	$54,000	3.94%	$100,375	3.64%	$117,804	3.79%
Colorado	$57,200	3.55%	$58,916	3.56%	$19,500	3.88%	$48,000	2.59%	$94,703	4.12%	$107,996	4.36%
Connecticut	$49,192	2.50%	$52,624	1.84%	$22,100	1.22%	$56,400	-1.23%	$151,475	1.46%	$164,798	1.75%
District of Columbia	N/A	N/A	N/A	N/A	N/A	N/A	$111,195	N/A	$109,500	3.71%	$116,800	2.13%
Delaware	$48,620	1.09%	$52,624	0.85%	$21,570	5.83%	$64,200	-0.67%	$125,925	4.72%	$131,400	4.13%
Florida	$45,646	2.14%	$46,904	2.07%	$17,550	2.38%	$42,000	3.13%	$97,820	3.56%	$108,770	3.58%
Georgia	$43,472	2.25%	$45,760	2.71%	$15,600	-0.51%	$37,200	2.78%	$76,103	3.80%	$81,213	3.76%
Hawaii	$57,200	1.25%	$68,640	3.71%	$19,760	1.66%	$66,000	5.54%	$146,000	2.74%	$163,885	2.44%
Iowa	$54,912	3.26%	$57,200	3.30%	$16,237	3.73%	$46,158	4.08%	$73,000	4.40%	$77,745	3.95%
Idaho	$45,760	1.57%	$45,760	1.57%	$31,200	5.23%	$41,700	1.68%	$90,885	2.14%	$96,543	2.22%
Illinois	$50,336	2.98%	$51,480	1.88%	$18,806	1.02%	$48,360	-0.10%	$70,993	2.73%	$81,030	2.84%
Indiana	$48,048	3.13%	$50,336	2.98%	$22,100	4.11%	$52,620	3.43%	$82,308	2.95%	$98,915	2.89%
Kansas	$45,760	2.13%	$48,048	2.46%	$21,125	4.56%	$54,675	5.48%	$64,970	2.81%	$70,379	2.31%
Kentucky	$45,760	3.30%	$46,904	3.22%	$17,550	3.09%	$42,240	5.29%	$82,125	2.33%	$91,250	2.31%
Louisiana	$36,608	2.71%	$36,608	1.30%	$16,380	2.02%	$42,600	2.42%	$62,780	2.78%	$66,503	2.65%
Massachusetts	$58,916	2.28%	$62,005	2.29%	$17,332	2.13%	$65,940	2.11%	$144,175	2.74%	$153,300	2.85%
Maryland	$49,169	2.77%	$50,908	2.16%	$20,800	0.90%	$56,070	6.56%	$110,778	3.95%	$116,070	3.01%
Maine	$57,200	4.05%	$59,488	3.40%	$28,600	2.25%	$59,400	1.92%	$113,150	2.80%	$121,180	3.10%
Michigan	$50,336	2.98%	$52,624	3.36%	$20,800	3.53%	$46,200	6.20%	$102,748	4.12%	$109,500	3.30%
Minnesota	$61,776	5.15%	$66,352	3.01%	$21,580	4.69%	$48,000	3.61%	$109,500	8.72%	$122,260	8.87%
Missouri	$45,760	3.30%	$48,048	3.13%	$21,840	3.71%	$34,128	4.45%	$60,225	2.65%	$66,521	2.77%
Mississippi	$38,896	0.32%	$38,896	0.00%	$9,100	-11.09%	$41,910	3.09%	$80,300	1.92%	$85,045	2.35%
Montana	$54,912	3.71%	$54,912	2.71%	$29,614	7.32%	$47,028	1.71%	$84,067	3.08%	$87,717	2.02%
North Carolina	$42,328	1.71%	$45,188	2.45%	$14,300	1.92%	$44,318	4.95%	$83,403	3.06%	$92,528	3.62%
North Dakota	$61,776	2.99%	$61,776	2.99%	$29,029	12.16%	$39,780	3.05%	$132,320	8.61%	$140,277	8.98%

Annual Median Costs

	Home Health Care				Adult Day Health Care		Assisted Living Facility*		Nursing Home Care			
LOCATION	HOMEMAKER SERVICES[1]	5-YEAR ANNUAL GROWTH[2]	HOME HEALTH AIDE[1]	5-YEAR ANNUAL GROWTH[2]	ADULT DAY HEALTH CARE[3]	5-YEAR ANNUAL GROWTH[2]	PRIVATE, ONE BEDROOM[4]	5-YEAR ANNUAL GROWTH[2]	SEMI-PRIVATE ROOM[5]	5-YEAR ANNUAL GROWTH[2]	PRIVATE ROOM[5]	5-YEAR ANNUAL GROWTH[2]
Nebraska	$53,768	4.07%	$54,912	1.85%	$18,655	8.60%	$46,131	2.73%	$82,855	5.04%	$87,191	3.88%
New Hampshire	$57,200	2.59%	$61,776	2.60%	$20,410	3.85%	$56,100	5.43%	$124,100	2.88%	$133,225	2.04%
New Jersey	$54,912	3.20%	$54,912	2.71%	$23,400	2.38%	$72,780	0.24%	$127,750	3.17%	$142,350	3.27%
New Mexico	$41,184	-0.55%	$45,760	0.12%	$26,598	6.30%	$51,000	3.86%	$87,418	4.25%	$91,433	2.77%
Nevada	$50,336	1.92%	$50,336	0.94%	$18,720	2.07%	$42,000	4.19%	$98,733	4.07%	$111,143	4.44%
New York	$56,285	4.23%	$57,200	2.59%	$19,500	0.00%	$50,220	1.16%	$141,073	3.12%	$146,274	3.07%
Ohio	$48,048	2.73%	$49,192	2.50%	$15,860	3.24%	$51,336	1.76%	$85,410	2.86%	$94,900	2.93%
Oklahoma	$45,760	2.13%	$49,718	2.78%	$15,600	0.00%	$39,900	2.31%	$55,663	2.47%	$63,510	2.79%
Oregon	$58,344	4.98%	$59,488	4.36%	$23,790	-0.62%	$55,110	2.69%	$111,325	5.62%	$119,720	5.25%
Pennsylvania	$50,336	2.71%	$51,777	2.50%	$16,900	3.03%	$45,000	3.39%	$115,340	4.04%	$121,363	3.06%
Rhode Island	$58,344	4.98%	$61,776	3.30%	$19,500	2.90%	$52,200	0.96%	$105,850	0.70%	$116,800	0.96%
South Carolina	$43,472	2.25%	$45,760	2.13%	$15,595	3.71%	$42,000	3.13%	$77,015	2.23%	$86,505	3.35%
South Dakota	$54,912	3.71%	$57,200	4.56%	$18,460	11.47%	$42,000	2.88%	$79,388	2.69%	$84,863	2.74%
Tennessee	$43,358	2.20%	$45,188	2.48%	$17,420	2.58%	$47,040	2.15%	$76,650	2.79%	$82,125	2.80%
Texas	$45,760	2.19%	$45,760	2.13%	$9,100	1.18%	$45,540	2.61%	$57,579	3.91%	$78,475	5.06%
Utah	$50,336	1.92%	$50,336	0.93%	$12,090	-3.56%	$40,200	3.02%	$73,000	3.92%	$91,250	4.83%
Virginia	$45,760	3.30%	$48,048	3.13%	$18,200	3.13%	$53,415	3.35%	$89,425	3.73%	$102,200	4.01%
Vermont	$61,776	5.15%	$61,776	2.38%	$35,360	1.00%	$54,000	3.71%	$113,698	3.21%	$118,808	1.99%
Washington	$64,064	5.43%	$64,064	4.52%	$16,900	-0.77%	$61,620	3.86%	$104,025	3.25%	$116,618	3.97%
Wisconsin	$53,768	3.28%	$54,912	2.22%	$16,900	0.95%	$51,600	3.98%	$100,010	2.84%	$112,146	3.00%
West Virginia	$37,752	0.83%	$38,896	1.22%	$15,600	-2.90%	$43,425	2.17%	$123,370	7.42%	$132,860	7.75%
Wyoming	$50,336	2.18%	$57,200	4.83%	$28,990	6.87%	$50,820	5.12%	$86,140	3.52%	$90,520	3.58%

Genworth Cost of Care Survey 2018, conducted by CareScout®, June 2018

[1] Based on 44 hours per week by 52 weeks

[2] Represents the compound annual growth rate based on Genworth Cost of Care Survey

[3] Based on 5 days per week by 52 weeks

[4] Based on 12 months of care, private, one bedroom

[5] Based on 365 days of care

* Referred to as Residential Care Facility in California

N/A = Not Available

Monthly Median Costs

	Home Health Care		Adult Day Health Care	Assisted Living Facility*	Nursing Home Care	
LOCATION	HOMEMAKER SERVICES[1]	HOME HEALTH AIDE[1]	ADULT DAY HEALTH CARE[1]	PRIVATE, ONE BEDROOM[2]	SEMI-PRIVATE ROOM[1]	PRIVATE ROOM[1]
USA – National	$4,004	$4,195	$1,560	$4,000	$7,441	$8,365
Alaska	$4,957	$5,148	$2,281	$6,300	$29,291	$27,573
Alabama	$3,241	$3,241	$758	$3,271	$6,279	$6,661
Arkansas	$3,432	$3,609	$1,733	$3,037	$5,353	$5,986
Arizona	$4,338	$4,433	$2,004	$3,800	$6,494	$7,908
California	$4,957	$4,957	$1,679	$4,500	$8,365	$9,817
Colorado	$4,767	$4,910	$1,625	$4,000	$7,892	$9,000
Connecticut	$4,099	$4,385	$1,842	$4,700	$12,623	$13,733
District of Columbia	N/A	N/A	N/A	$9,266	$9,125	$9,733
Delaware	$4,052	$4,385	$1,797	$5,350	$10,494	$10,950
Florida	$3,804	$3,909	$1,463	$3,500	$8,152	$9,064
Georgia	$3,623	$3,813	$1,300	$3,100	$6,342	$6,768
Hawaii	$4,767	$5,720	$1,647	$5,500	$12,167	$13,657
Iowa	$4,576	$4,767	$1,353	$3,847	$6,083	$6,479
Idaho	$3,813	$3,813	$2,600	$3,475	$7,574	$8,045
Illinois	$4,195	$4,290	$1,567	$4,030	$5,916	$6,753
Indiana	$4,004	$4,195	$1,842	$4,385	$6,859	$8,243
Kansas	$3,813	$4,004	$1,760	$4,556	$5,414	$5,865
Kentucky	$3,813	$3,909	$1,463	$3,520	$6,844	$7,604
Louisiana	$3,051	$3,051	$1,365	$3,550	$5,232	$5,542
Massachusetts	$4,910	$5,167	$1,444	$5,495	$12,015	$12,775
Maryland	$4,097	$4,242	$1,733	$4,673	$9,231	$9,673
Maine	$4,767	$4,957	$2,383	$4,950	$9,429	$10,098
Michigan	$4,195	$4,385	$1,733	$3,850	$8,562	$9,125
Minnesota	$5,148	$5,529	$1,798	$4,000	$9,125	$10,188
Missouri	$3,813	$4,004	$1,820	$2,844	$5,019	$5,543
Mississippi	$3,241	$3,241	$758	$3,493	$6,692	$7,087
Montana	$4,576	$4,576	$2,468	$3,919	$7,006	$7,310
North Carolina	$3,527	$3,766	$1,192	$3,693	$6,950	$7,711
North Dakota	$5,148	$5,148	$2,419	$3,315	$11,027	$11,690

Monthly Median Costs

	Home Health Care		Adult Day Health Care	Assisted Living Facility*	Nursing Home Care	
LOCATION	HOMEMAKER SERVICES[1]	HOME HEALTH AIDE[1]	ADULT DAY HEALTH CARE[1]	PRIVATE, ONE BEDROOM[2]	SEMI-PRIVATE ROOM[1]	PRIVATE ROOM[1]
Nebraska	$4,481	$4,576	$1,555	$3,844	$6,905	$7,266
New Hampshire	$4,767	$5,148	$1,701	$4,675	$10,342	$11,102
New Jersey	$4,576	$4,576	$1,950	$6,065	$10,646	$11,863
New Mexico	$3,432	$3,813	$2,217	$4,250	$7,285	$7,619
Nevada	$4,195	$4,195	$1,560	$3,500	$8,228	$9,262
New York	$4,690	$4,767	$1,625	$4,185	$11,756	$12,189
Ohio	$4,004	$4,099	$1,322	$4,278	$7,118	$7,908
Oklahoma	$3,813	$4,143	$1,300	$3,325	$4,639	$5,293
Oregon	$4,862	$4,957	$1,983	$4,593	$9,277	$9,977
Pennsylvania	$4,195	$4,315	$1,408	$3,750	$9,612	$10,114
Rhode Island	$4,862	$5,148	$1,625	$4,350	$8,821	$9,733
South Carolina	$3,623	$3,813	$1,300	$3,500	$6,418	$7,209
South Dakota	$4,576	$4,767	$1,538	$3,500	$6,616	$7,072
Tennessee	$3,613	$3,766	$1,452	$3,920	$6,388	$6,844
Texas	$3,813	$3,813	$758	$3,795	$4,798	$6,540
Utah	$4,195	$4,195	$1,008	$3,350	$6,083	$7,604
Virginia	$3,813	$4,004	$1,517	$4,451	$7,452	$8,517
Vermont	$5,148	$5,148	$2,947	$4,500	$9,475	$9,901
Washington	$5,339	$5,339	$1,408	$5,135	$8,669	$9,718
Wisconsin	$4,481	$4,576	$1,408	$4,300	$8,334	$9,346
West Virginia	$3,146	$3,241	$1,300	$3,619	$10,281	$11,072
Wyoming	$4,195	$4,767	$2,416	$4,235	$7,178	$7,543

Genworth Cost of Care Survey 2018, conducted by CareScout®, June 2018

[1] Based on annual rate divided by 12 months

[2] As reported, monthly rate, private, one bedroom

* Referred to as Residential Care Facility in California

N/A = Not Available

Daily Median Costs

	Home Health Care		Adult Day Health Care	Assisted Living Facility*	Nursing Home Care	
LOCATION	HOMEMAKER SERVICES[1]	HOME HEALTH AIDE[1]	ADULT DAY HEALTH CARE[2]	PRIVATE, ONE BEDROOM[1]	SEMI-PRIVATE ROOM[2]	PRIVATE ROOM[2]
USA – National	$132	$138	$72	$132	$245	$275
Alaska	$163	$169	$105	$207	$963	$907
Alabama	$107	$107	$35	$108	$206	$219
Arkansas	$113	$119	$80	$100	$176	$197
Arizona	$143	$146	$93	$125	$214	$260
California	$163	$163	$78	$148	$275	$323
Colorado	$157	$161	$75	$132	$259	$296
Connecticut	$135	$144	$85	$155	$415	$452
District of Columbia	N/A	N/A	N/A	$305	$300	$320
Delaware	$133	$144	$83	$176	$345	$360
Florida	$125	$129	$68	$115	$268	$298
Georgia	$119	$125	$60	$102	$209	$223
Hawaii	$157	$188	$76	$181	$400	$449
Iowa	$150	$157	$62	$126	$200	$213
Idaho	$125	$125	$120	$114	$249	$265
Illinois	$138	$141	$72	$132	$195	$222
Indiana	$132	$138	$85	$144	$226	$271
Kansas	$125	$132	$81	$150	$178	$193
Kentucky	$125	$129	$68	$116	$225	$250
Louisiana	$100	$100	$63	$117	$172	$182
Massachusetts	$161	$170	$67	$181	$395	$420
Maryland	$135	$139	$80	$154	$304	$318
Maine	$157	$163	$110	$163	$310	$332
Michigan	$138	$144	$80	$127	$282	$300
Minnesota	$169	$182	$83	$132	$300	$335
Missouri	$125	$132	$84	$94	$165	$182
Mississippi	$107	$107	$35	$115	$220	$233
Montana	$150	$150	$114	$129	$230	$240
North Carolina	$116	$124	$55	$121	$229	$254
North Dakota	$169	$169	$112	$109	$363	$384

Daily Median Costs

	Home Health Care		Adult Day Health Care	Assisted Living Facility*	Nursing Home Care	
LOCATION	HOMEMAKER SERVICES[1]	HOME HEALTH AIDE[1]	ADULT DAY HEALTH CARE[2]	PRIVATE, ONE BEDROOM[1]	SEMI-PRIVATE ROOM[2]	PRIVATE ROOM[2]
Nebraska	$147	$150	$72	$126	$227	$239
New Hampshire	$157	$169	$79	$154	$340	$365
New Jersey	$150	$150	$90	$199	$350	$390
New Mexico	$113	$125	$102	$140	$240	$251
Nevada	$138	$138	$72	$115	$271	$305
New York	$154	$157	$75	$138	$387	$401
Ohio	$132	$135	$61	$141	$234	$260
Oklahoma	$125	$136	$60	$109	$153	$174
Oregon	$160	$163	$92	$151	$305	$328
Pennsylvania	$138	$142	$65	$123	$316	$333
Rhode Island	$160	$169	$75	$143	$290	$320
South Carolina	$119	$125	$60	$115	$211	$237
South Dakota	$150	$157	$71	$115	$218	$233
Tennessee	$119	$124	$67	$129	$210	$225
Texas	$125	$125	$35	$125	$158	$215
Utah	$138	$138	$47	$110	$200	$250
Virginia	$125	$132	$70	$146	$245	$280
Vermont	$169	$169	$136	$148	$312	$326
Washington	$176	$176	$65	$169	$285	$320
Wisconsin	$147	$150	$65	$141	$274	$307
West Virginia	$103	$107	$60	$119	$338	$364
Wyoming	$138	$157	$112	$139	$236	$248

Genworth Cost of Care Survey 2018, conducted by CareScout®, June 2018

[1] Based on annual rate divided by 365 days

[2] As reported, daily rate

[3] Based on annual rate divided by 365 days, private, one bedroom

* Referred to as Residential Care Facility in California

N/A = Not Available

Hourly Median Costs

	Home Health Care	
LOCATION	HOMEMAKER SERVICES[1]	HOME HEALTH AIDE[1]
USA – National	$21.00	$22.00
Alaska	$26.00	$27.00
Alabama	$17.00	$17.00
Arkansas	$18.00	$18.93
Arizona	$22.75	$23.25
California	$26.00	$26.00
Colorado	$25.00	$25.75
Connecticut	$21.50	$23.00
District of Columbia	N/A	N/A
Delaware	$21.25	$23.00
Florida	$19.95	$20.50
Georgia	$19.00	$20.00
Hawaii	$25.00	$30.00
Iowa	$24.00	$25.00
Idaho	$20.00	$20.00
Illinois	$22.00	$22.50
Indiana	$21.00	$22.00
Kansas	$20.00	$21.00
Kentucky	$20.00	$20.50
Louisiana	$16.00	$16.00
Massachusetts	$25.75	$27.10
Maryland	$21.49	$22.25
Maine	$25.00	$26.00
Michigan	$22.00	$23.00
Minnesota	$27.00	$29.00
Missouri	$20.00	$21.00
Mississippi	$17.00	$17.00
Montana	$24.00	$24.00
North Carolina	$18.50	$19.75
North Dakota	$27.00	$27.00

Adult Day Health Care, Assisted Living Facility, and Nursing Home Care categories do not use hourly rates.

Hourly Median Costs

	Home Health Care	
LOCATION	HOMEMAKER SERVICES[1]	HOME HEALTH AIDE[1]
Nebraska	$23.50	$24.00
New Hampshire	$25.00	$27.00
New Jersey	$24.00	$24.00
New Mexico	$18.00	$20.00
Nevada	$22.00	$22.00
New York	$24.60	$25.00
Ohio	$21.00	$21.50
Oklahoma	$20.00	$21.73
Oregon	$25.50	$26.00
Pennsylvania	$22.00	$22.63
Rhode Island	$25.50	$27.00
South Carolina	$19.00	$20.00
South Dakota	$24.00	$25.00
Tennessee	$18.95	$19.75
Texas	$20.00	$20.00
Utah	$22.00	$22.00
Virginia	$20.00	$21.00
Vermont	$27.00	$27.00
Washington	$28.00	$28.00
Wisconsin	$23.50	$24.00
West Virginia	$16.50	$17.00
Wyoming	$22.00	$25.00

Genworth Cost of Care Survey 2018, conducted by CareScout®, June 2018

[1] As reported, hourly rate

N/A = Not Available

Adult Day Health Care, Assisted Living Facility, and Nursing Home Care categories do not use hourly rates.

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By Tom Henderson • Staff Writer • December 20, 2018

Fire department beefs up inspections

McMinnville business owners might be seeing a surprise visitor in the next few months — a fire inspector.

Fire Marshal Debbie McDermott said fire inspections have been rare in recent years, primarily because she has been the only person conducting them.

The hiring of Steve Candela as deputy fire marshal a year and a half ago enables the fire department to inspect additional businesses more frequently, McDermott said.

"Historically, over the past 20 years that I've been here, there have been two of us," she said. "Over the last 10 years, it's been just me and an assistant for public education."

As a result, she had to focus her inspections on schools, care centers and other facilities where regular inspections are required by state and federal law. "We haven't been able to get into a lot of businesses," McDermott said.

Fire Chief Rich Leipfert approached the city council two years ago expressing the need for increased code enforcement, and councilors approved the funds to hire Candela.

Care centers, although regularly inspected before, are getting an even closer scrutiny from the fire department.

"We would like to get into them more regularly," McDermott said. "There are a lot of people who reside there who can't get out in the case of an emergency."

She added that care centers often have high staff turnovers, and new personnel require constant training on issues such as evacuating residents and using fire extinguishers.

"If we can educate people, they're going to understand why they can't do such things as prop open a door to take laundry in and out," McDermott said.

Plus, she said, the buildings themselves need regular inspections. When she shouldered the entire burden of the

inspections herself, McDermott said, a center may be inspected just once every other year.

“It’s important we get in there and look at the building’s system and make sure it’s being taken care of properly,” she said. “We do find fire codes violations at varying levels.”

However, she added, care center operators shouldn’t feel singled out. Neither should any other local business owners.

“We’re not targeting any specific types of business,” she said. “We’re trying to work through them in a systematic way and get them on a regular schedule.”

In recent weeks, Candela has been inspecting industrial properties.

“We’re definitely getting out more into the industrial area,” McDermott said. “We just didn’t have a deputy for fire safety inspections. Now we have someone who is dedicated to go out there.”

Common findings during inspections include business owners adding or altering fire safety features without city permits. Whenever something is added or changed — whether a fire door or sprinkler system — McDermott said the action requires a permit from the city’s building department.

“Business owners don’t necessarily know when permits are required,” she said. “We’ve never once shut down a business for not having a permit. We really try to work with the buliding owner.”

Code enforcement in general has increased in McMinnville recently. Enforcment outside of fire codes was transferred from the police department to the planning department last summer.

Two new code compliance officers, Nic Miles and Claudia Martinez, work with property owners and tenants on issues such as junk cars, overgrown lawns and other code violations.

“They have been great, visiting with property owners about solutions with a mind toward compliance,” said Planning Director Heather Richards.

She said her staff is also working on a new program that emphasizes voluntary compliance and, failing that, billing property owners for city crews to correct the code violation themselves. Eventually, uncooperative property owners could face liens on their property.

“This will take most cases out of the municipal court system, which is very costly to the general taxpayer paying for court staff and court time,” Richards said.

However, she said, the main goal of all code enforcement programs is cooperation.

“We have also been in dialogue with many city and regional partners to talk about proactive neighborhood clean-up days and activities and we will be putting together an annual calendar of those events,” Richards said.

City Manager Jeff Towery is pleased with the results of code enforcement, both in the planning and fire departments.

“I think they’re rocking and rolling,” he said. “They have some some real successes in getting some chronic places cleaned up.”

A presentation on code enforcement activities is scheduled for the Tuesday, Jan. 8, council meeting.

McDermott said she is happy to work with Candela and handle the backlog of inspections.

“We’re really getting too big a city just to have one person,” she said. “It’s very nice to have some help. Our city has grown a ton in the 20 years I’ve been here. Code enforcement is very important.”

CARE FACILITY – NEWS CLIPPINGS (abridged)

Contents

OREGON HEADLINES

Neglect at Ashland nursing home caused 'extended suffering' for weeks, suit claims. March 3, 2019

A suit claiming negligence and abuse seeks up to $18 million from Linda Vista Nursing and Rehab Center, three employees and parent company Prestige Care of Vancouver. One of those employees has been indicted on seven felony charges.

Neglect victim smelled of 'rotting flesh,' state finds, shuttering home for people with disabilities. January 10, 2019

A national corporation shuttered a Brookings group home for people with disabilities last month after state

regulators found that managers repeatedly ignored caregivers' concerns about a disabled person's festering pressure wound, including that it smelled of "rotting flesh."

State regulators for the Department of Human Services moved to revoke the home's license before the company's local affiliate, Mentor Oregon, closed the facility along the Southern Oregon coast Dec. 11.

Ashland memory care center found in non-compliance; residents at risk for harm. December 27, 2018

An investigation by NewsWatch 12 reveals that state health officials are stepping in to make sure dementia patients are safe at an Ashland facility.

The Village at Valley View opened on July 26, 2017, and the Oregon Department of Human Services (DHS) opened an investigation in December. They started interviewing current and former staff about neglect and the off-label use of medication that sedated patients.

By February 2018, adult protective services brought in a consultant to evaluate and review the facility.

NewsWatch12's Sionan Barrett submitted a public records request to DHS on February 8. On March 5, Barrett received the documents detailing the investigation.

DHS found 24 serious violations of residents' rights in the investigation, and concluded that the facility's, "non-compliance places residents at harm or risk for harm."

Knute Buehler calls for tougher memory care rules after Oregonian investigation October 27, 2018

Knute Buehler, the Republican candidate for governor, is calling for tougher staffing requirements in Oregon memory care facilities following an investigation by The Oregonian/OregonLive that revealed rampant problems.

In an interview this week, Buehler said the state should impose precise numeric hiring standards on memory care facilities, a move that advocates say is essential to limit abuse but that the industry says could drive up costs.

Rampant turnover, low pay: Insiders on Oregon dementia care. October 12, 2018

Grueling work. Rampant turnover. Elderly people with dementia, abused and neglected for lack of staff.

The Oregonian/OregonLive asked more than 200 current and former memory care employees what they experienced on the job. Their stunning responses shed light on why memory care too often falls short of its promise of specialized support for people with dementia.

Family files $1.27 million wrongful death lawsuit against Keizer nursing home. September 27, 2018

The family of a woman who died following a 2015 fall at Avamere Court at Keizer is suing the nursing home for $1.27 million.

The wrongful death lawsuit, filed Monday in Marion County Circuit Court, accuses the care home staff of negligence and abuse of a vulnerable person.

A follow-up investigation by the Oregon Department of Human Services found staff acted negligently and failed to provide necessary care and a safe environment.

Officials with Avamere Court at Keizer declined to comment on the ongoing lawsuit.

The 69-bed facility has a current state license and certification. It has been inspected at least once yearly and was licensed at the time of the incident.

Family worries woman's death at Lebanon care facility was due to neglect. June 20, 2018

LEBANON, Ore. — Lebanon Police, Adult Protective Services and Oregon DHS are all investigating the Bridgecreek Memory Care Community after the death of one of its residents last weekend.

Bridgecreek Memory Care license restricted following death, resident's repeated falls. June 21, 2018

LEBANON — The Lebanon Police Department and Oregon Cascades West Council of Governments' adult protective services department are investigating the death of a resident of Bridgecreek Memory Care, 1401 12th St.

Sue Richards, 82, who was suffering from Alzheimer's disease, died Sunday night, and her son Greg Richards contacted the Lebanon Police Department with concerns about neglect.

Baycrest Memory Care has closed its doors. April 27, 2018

COOS BAY – Baycrest Memory Care has shut down.

The facility emptied its rooms and closed its doors on March 1 under the supervision of the Department of Human Services. This followed dozens of abuse and neglect investigations until DHS sent a notice of intent to revoke its license. Rather than make moves to improve, Bay Area Properties, LLC announced the facility's closure back in December.

Bend memory care facility sued for $2.6 million. December 31, 2017

When Jon Valley moved his brother, Jeff, into Aspen Ridge Memory Care, he assumed he would be in good hands, he said.

However, Jeff Valley — a former Special Olympian and beloved fixture at several Bend barbershops, known for his happy demeanor — lost 20 pounds and became severely depressed, his family says. He was taken to St. Charles Bend multiple times for incidents including choking, an emergency surgery and a gash that required 17 stitches, Jon Valley said.

Now Jon Valley is suing the Bend facility for $2.6 million on behalf of his brother for alleged neglect and personal injury.

"In this case, Jeff puts his trust in his family who put their trust in the facility," said Mario Riquelme, the Valleys' lawyer. "We would like to see this case presented to a jury so that they can see what happened, where those standards of care were not met and ultimately do what is right not only for Jeff but for everyone else at these facilities. We would like to let any other like facilities know that those lapses and those breaches will not be tolerated and will not be acceptable."

Kept in the Dark: Oregon hides thousands of cases of shoddy senior care. April 21, 2017

Oregon officials have concealed from the public thousands of confirmed cases of

shoddy care and elder abuse, whitewashing safety records at hundreds of homes for seniors across the state.

The Department of Human Services operates a website that is supposed to help consumers identify safe havens for their aging loved ones, including those suffering from Alzheimer's and other debilitating illnesses.

But an investigation by The Oregonian/OregonLive found that officials have excluded nearly 8,000 substantiated complaints of substandard care from the state's website.

State orders care facility to correct safety issues. May 20, 2016

The state Department of Human Services is not allowing any new residents to be admitted to Sea View Assisted Living Community's Brightcreek memory care unit in Harbor, citing an array of possible violations following a "multitude" of investigations there.

Most of the violations were related to the lack of documentation regarding patient care. Signs have been posted on the building's entrances indicating no more residents will be accepted into Sea View's care until the violations are addressed satisfactorily.

Oregon Adult Protective Service investigations indicated in a 37-page report that the facility failed to "provide a safe medication administration system, update resident care plans and provide a safe and secure environment andhellip; that create a threat to the health and safety of the residents." Such practices violate nine Oregon Administrative Rules regarding the facility's license.

Some employees have already lost their jobs there, and Sea View has placed an ad looking for replacements. Sea View officials did not return the Pilot's numerous phone calls this week.

CALIFORNIA

Another Northern California care-home resident allegedly left in the sun, state says. February 26, 2019

Two months before Gene Rogers died from heat stroke after being left in his wheelchair on a patio at a Westmont Living care home in Roseville, another resident was left unattended outside for hours at a Chico facility run by the same company, state records show.

The incident at The Terraces' Compass Rose memory care center in Chico occurred April 23, when a regulators received a complaint that a resident "was left out in the sun for several hours," a state Department of Social Services report states.

Butte County paramedics who responded to the facility indicated that staffers there were unable to explain how the incident occurred, writing that "six staff were present and no one knew anything."

"Resident was left out in the sun for several hours," the state's report on the incident states. "It is unknown who left him out there from the AM shift, but he was found at 4:11 p.m.,

"Resident was red, sweaty and the weather was between 70-80 degrees."

The resident was found in an "altered level of consciousness" without a shirt on "and having dried vomit on his face, mouth and chest," the state report found, and paramedics had to suction out his throat "to help clear debris left over from vomiting."

The resident, who is not named in the report, died two weeks later, with an autopsy report stating that "significant conditions" found included "acute pneumonia" in both lungs

Left on patio in wheelchair, retired Marine died of heat stroke at Roseville care facility, lawsuit says. February 10, 2019

Gene Rogers lived a large life before dementia began to chip away at it.

A former Marine who signed up at 17 and fought in Korea, Rogers went on to become a stock car racer, earned an electronics degree and spent more than three decades working for AT&T as he and his wife, Kathryn, raised three boys during their 60-year marriage.

He spent his retirement in Carlsbad, living near Camp Pendleton where he started in the Marine Corps and where his passion for golf took him to a course nearly every day.

Then, he got sick.

Faced with the reality that 81-year-old Kathryn couldn't care for him alone, the family sold the Carlsbad home, banked the proceeds and found a pleasant, $5,540-a-month assisted living facility where Rogers could receive around-the-clock care in a secure environment.

On Dec. 30, 2017, Rogers went to live at Meadow Oaks of Roseville, a tan stucco facility along Linda Creek that touts itself as offering "well-being and a positive, active lifestyle."

Six months later, the 83-year-old Rogers was dead from heat stroke after allegedly being left alone on a patio in his wheelchair, then forgotten about for hours outside as the summer heat built. State licensing officials investigated the death and in October, announced their fine: $1,000.

Atria of Paradise sued for alleged elder abuse, negligence. September 11, 2018

Atria Paradise is being sued for alleged elder abuse and negligent hiring and supervision by the daughter of one of the assisted living facility's former residents.

A 27-page complaint was filed Sept. 5 in Butte County Superior Court by the late Maria Coffman's daughter, Anita Coffman, and Stephen Garcia, an attorney at Garcia, Artigliere & Medby. It claims that Maria, a 79-year-old woman with dementia and other medical conditions, was improperly admitted into the facility in 2017.

They claim in the suit that her health conditions should have prohibited Atria from retaining her as a resident of the non-medical residential care facility for the elderly. They argue residential care facilities for the elderly "are intended to provide a level of care appropriate for those unable to live by themselves, but who do not have medical conditions requiring more extensive nursing care and significant assistance with most of their personal activities of daily living."

FLORIDA

State calls for changes from assisted living facility banned from admitting new residents. December 12, 2018

The state is taking action after banning a Bay Area assisted living facility from admitting any new residents.

A day after I-Team Investigator Kylie McGivern reported on the moratorium, state regulators sent managers at Inspired Living at Sun City Center a letter, giving the facility 30 days to fix its problems.

The Agency for Health Care Administration (AHCA) wants the home that serves residents with dementia and Alzheimer's disease to put new safety plans in place to supervise residents and prevent abuse.

A state investigation into the facility found incidents of sexual assault and violent behavior by residents against other residents and said the assisted living facility didn't do enough to stop it.

ILLINOIS

Freeport (IL) proposes new lift assist fees for extended care facilities, private ambulances. February 20, 2019

When a nursing home patient can't get up, often times the Freeport Fire Department is called in to help. But firefighters say they're help is being taken advantage of.

"The issue that we've begun to have is when nursing homes, extended care facilities and private ambulances contact us for these type of lift assist services when they provide that on their own for profit," Freeport Fire Chief Todd Allen said.

And it can come at a big expense for firefighters. Back in September, a firefighter was hurt after helping with a lift assist at private healthcare facility.

"This particular injury was over $20,000 of costs to us, which is basically an issue that is a staffing for a healthcare facility that's charging that patient," Allen said.

That's why Freeport Fire is working with the city to propose a new ordinance.

MINNESOTA

Gov. Tim Walz proposes tougher oversight of Minnesota facilities for vulnerable adults. February 21, 2019

Proposal for more fines, more frequent inspections responds to flood of complaints.

The administration of Gov. Tim Walz is proposing a dramatic expansion of the state's powers to fight abuse and neglect of elderly and frail Minnesotans who live in care facilities across the state.

The multipronged proposal, outlined Tuesday in Walz's two-year budget plan, would subject care facilities to more frequent inspections and immediate fines in cases of health and safety violations. The state would also create a licensing system for assisted-living homes, which now serve more than 60,000 Minnesotans but operate under less supervision than nursing homes.

Investigators document neglect at Thief River Falls assisted living center. February 21, 2019

Minnesota investigators have uncovered evidence of neglect at a Thief River Falls assisted living facility.

State health officials in December 2018 visited the Valley Home assisted living facility to investigate an allegation of maltreatment, according to report from Minnesota's office of health facility complaints.

According to the allegation, a facility staff member demonstrated neglect by failing to seek medical intervention when a female client showed a "significant change in health status." The client died about an hour later, according to the report.

Lift Assist Calls Taxing MN Firefighters. December 9, 2018

Fire chiefs in Minnesota say that calls to lift people off the floor, including at senior care facilities, are taxing their crews.

Firefighters across Minnesota are increasingly responding to 911 calls to lift elderly people off the floor, even at some senior care facilities with their own staff.

More than 7,100 times last year, fire departments across the state were dispatched to assist frail but uninjured people, a nearly threefold increase from a decade prior. The

unreimbursed runs come at a cost to taxpayers — $825 per call, by one estimate — summoning a fire truck and several firefighters to perform a “lift assist” without medical treatment.

It is a worrying trend for many local fire departments already responding to mounting medical calls, since it can leave them shorthanded for major emergencies and puts firefighters at risk of back injuries. It also underscores the sometimes uneven care offered by senior housing complexes springing up across the metro area.

“These assisted living facilities charge a pretty hefty fee each month for the residents to stay there,” said Coon Rapids Fire Chief John Piper, who reduced the lift calls in his city after meeting with assisted living facilities. “As the name implies, it’s our view that that’s a service that they should provide.”

“Lift assist” calls typically involve people who fall doing routine tasks, like moving around the bathroom, and do not need medical help. These runs now make up almost 4 percent of all fire department medical runs, though the data probably understates the actual number, according to the state fire marshal. It includes people who call from their homes.

Cities across the country have begun charging facilities for lift assist runs, most recently Omaha, Tacoma, Wash., and Kansas City, Mo.

“I think it’s a growing problem with everyone,” said Dale Specken, Hopkins fire chief and president of the Metropolitan Fire Chiefs Association. “The busier that we’re getting with just calls in general and then lift assists ... a lot of them are ones that we end up at nursing facilities.”

Neglect cited in Duluth nursing facility death. August 22, 2018

Four nurses at a Duluth assisted living facility neglected a resident when they failed to perform CPR after the resident was found unresponsive, a state agency found.

The resident at Chris Jensen Health and Rehab Center died, according to a report by the Minnesota Department of Health's Office of Health Facility complaints.

The date of death is not listed in the report by special investigator Peggy Boeck, which the agency posted online Tuesday. The investigation concluded July 31 after site visits on June 12-13

State finds neglect in Aitkin assisted living facility. June 26, 2018

Failure to correctly monitor the blood sugar levels of a diabetic assisted living resident in Aitkin amounted to neglect, the Minnesota Department of Health concluded.

Golden Horizons in Aitkin was the site of a March investigation determining the home care provider failed to comply with hospital orders to increase the number of blood sugar checks on an unidentified resident. The resident—a Type 2 diabetic with dementia—went to the hospital several times with high blood sugar before ultimately dying, a death partially attributed to diabetes and its complications. The state's Office of Health Facility Complaints reported its findings Tuesday, June 19.

"Based on a preponderance of evidence, neglect is substantiated," the report stated. "The home care provider failed to implement hospital orders for increased monitoring of the client's blood sugars and therefore had insufficient information to provide to the client's physician when requesting changes to the client's insulin regimen."

NEBRASKA

Omaha City (NE) Council passes lift assist fee. Sep 12, 2018

NORTH CAROLINA

State suspends assisted living facility's license after finding 'evidence of neglect'. October 22, 2018

LAKE WACCAMAW, NC (WECT) - The state has summarily suspended the operations of an assisted living facility in Columbus County after an investigation found "evidence of neglect and failure to protect residents from potential harm that presents an imminent danger to the health and welfare of residents in the home."

The N.C. Division of Health Service Regulation, a division of the N.C. Department of Health and Human Services, suspended Lake Pointe Assisted Living's license on Oct. 17. The DHSR, Columbus County Department of Social Services, and Trillium LME/MCO helped relocate all of the residents from the facility, located at 206 Wananish Avenue in Lake Waccamaw, to other locations.

NEW MEXICO

Santa Fe senior living facility faces wrongful death suit. February 20, 2019

It's unclear how long Julian Gaul lay on his back the evening of Feb. 27, 2017, looking up at the ceiling of his room at Pacifica Senior Living. It would be at least an hour and a half before staff at the assisted living center found the man lying in the gap between his wheelchair and bed, and transported him to Christus St. Vincent Regional Medical Center, according to a new wrongful death lawsuit against the facility.

Blood had been collecting in Gaul's brain for some time, likely from an earlier fall, a doctor informed the man's son, Fred Gaul. Julian Gaul, 83, was returned to Pacifica just before midnight.

Less than 24 hours later, he was found on the floor again. No one saw Gaul fall hard on his face, breaking his nose and cutting a wide gash across his forehead that required six stitches. It was at least his fifth fall in as many months, his son said.

"At the hospital, they cleaned him up from top to bottom," Fred Gaul said in an interview. "In his groin region, he had sores. He had fungus growing on his genitalia because he hadn't been cleaned in at least three months."

Doctors found Gaul lethargic, Fred Gaul said, with his communication and cognitive skills impaired.

"My dad was gone three days later," he said.

OHIO

A nursing home patient 'rotted to death' under nurses' care, Ohio official says. February 15, 2019

Current and former employees of an Ohio nursing facility are accused of mistreating two patients in their care, including one who died as a result of the nurses' actions, Attorney General Dave Yost said Thursday.

A Franklin County grand jury indicted seven people who worked as nurses in 2017 at Whetstone Gardens and Care Center in Columbus, Yost said in a news conference.

The defendants face 34 charges, including involuntary manslaughter and patient neglect, Yost's office said.

One patient "literally rotted to death" as a direct result of the nurses' neglect, Yost said, adding that another suffered physical harm because nurses falsified her medical records and forged signatures.

Decatur fire chief: Non-emergency calls straining department resources. Mar 3, 2018

DECATUR — The Decatur Fire Department is looking for ways to reduce its responses to non-emergency calls at commercial facilities for the elderly, citing a steady increase in calls straining department resources over the past decade.

Fire Chief Jeff Abbott said the department in particular is looking to reduce "lift-assist" calls, which typically involve a fallen person needing to be helped up or receive other medical assistance. Firefighters and ambulance personnel are dispatched to these calls at the same time.

The problem is not the lift-assist calls themselves, Abbott said, but rather frequent callers from commercial facilities who he said are taking advantage of the system. Constantly responding to non-emergency calls greatly strains the department's resources, he said. Solutions, Abbott said, could include ranking emergency calls and a city ordinance that would charge commercial facilities for lift-assistance calls.

"I'm not talking about the person who falls down and they've been a taxpayer their whole life and they call the fire department," he said. "Our first venture is going to be dealing with commercial facilities who have been using us to circumvent their own liability insurance."

Although the city's population has declined in the past 20 years, the fire department is responding to double the number of calls, Abbott said.

The number of alarms is increasing each year. In 2015, the department responded to 10,317 alarms, according to city records. In 2016, it reported a new record of 11,085 calls, which was broken again the next year: In 2017, the department responded to 11,342 calls. Of those, 698 were for lift-assists.

PENNSYLVANIA

Overdoses, bedsores, broken bones: What happened when a private-equity firm sought to care for society's most vulnerable. November 25, 2018

POTTSVILLE, Pa. — To the state inspectors visiting the HCR ManorCare nursing home here last year, the signs of neglect were conspicuous. A disabled man who had long, dirty fingernails told them he was tended to "once in a blue moon." The bedside "call buttons" were so poorly staffed that some residents regularly soiled themselves while waiting for help to the bathroom. A woman dying of uterine cancer was left on a bedpan for so long that she bruised.

The lack of care had devastating consequences. One man had been dosed with so many opioids that he had to be rushed to a hospital, according to the inspection reports. During an undersupervised bus trip to church — one staff member was escorting six patients who could not walk without help — a resident flipped backward on a wheelchair ramp and suffered a brain hemorrhage.

When a nurse's aide who should have had a helper was trying to lift a paraplegic woman, the woman fell and fractured her hip, her head landing on the floor beneath her roommate's bed.

"It was horrible — my mom would call us every day crying when she was in there," said Debbie Bojo, whose mother was treated at ManorCare's Pottsville facility in

September 2016. “It was dirty — like a run-down motel. Roaches and ants all over the place.”

TEXAS

Unbathed, sick, bruised — family says Texas nursing home neglected mom to death. December 13, 2018

BROWNWOOD

A nursing home in Brownwood was cited for neglect by the state, and a family says their mother died at the facility’s hands.

Vicky Brown’s daughter, Shelly Cameron, and Brown’s son, John Weldon, are suing Cross Country Healthcare Center for what they say was neglect of their mother.

Cameron said she originally did not want to sue anybody, but felt a responsibility to make sure no one else is treated the way her mother was.

“After seeing what happened to her, we didn’t have a choice,” Cameron said. “You just can’t let this go, it’s going to happen to somebody else. It’s going to happen to somebody else’s mom.”

Report: Assisted living residents left in peril as Hurricane Harvey hit. August 3, 2018

As chaos descended during Hurricane Harvey, dozens of elderly and medically vulnerable residents at four area assisted living facilities were left trapped, in danger, or simply abandoned amid the rising water, state investigators have concluded.

In previously undisclosed findings, state inspectors tracked complaints to the Texas Health and Human Services Commission and discovered dangerous conditions — some deeply disturbing — at three assisted living facilities in Houston and one in Victoria.

WASHINGTON

New fines in Tacoma for false fire alarms, 911 nonemergency calls from care centers. November 23, 2018

The “lift assistance” fine won’t be levied for calls involving people who have fallen in private residences, parks, at the Tacoma Mall or other public spaces.

The Fire Department notes that each year it responds to 350 to 360 nonemergency calls for falls.

“We don’t want be in the business of lifting patients in nonemergency situations,” Fire Chief James Duggan said at a City Council study session Oct. 23. “We want to make sure that it isn’t less expensive to simply continue to call the Fire Department instead of purchasing the required equipment and having the required staffing.”

NATIONAL

Impact of List Assist Calls on Paramedic Services: A Descriptive Study. Mar-Apr 2019

Prehospital Emergency Care: official journal of the National Association of EMS Physicians and the National Association of State EMS Directors

Abstract

Introduction: The aging population in Canada is steadily increasing and is placing greater demand on paramedic services, especially through the growing number of non-emergent lift assist (LA) calls. A LA occurs when a person calls paramedic

services and requests assistance to get up or mobilize, usually after experiencing a fall. The patient refuses transport to the emergency department for further medical attention. LA calls are time consuming and are non-reimbursable. The increase in number of this call type, specifically amongst older adults, is placing strain on paramedic services. **Objectives:** The purpose of this study was to describe the characteristics of LA calls in patients aged 65 and older and determine their impact on paramedic services. **Conclusion:** LAs consume the time of paramedics, preventing them from responding to more urgent emergency calls. Alternative solutions are needed to reduce the negative impact of LAs on paramedic services.

Study Targets For-Profit Nursing Homes Over Higher Risk of Neglect. October 21, 2018

New research from the University of Illinois at Chicago suggests that residents in for-profit nursing homes have the highest risk of receiving neglect-related diagnoses, and its authors claim the industry needs stronger oversight across all facility types.

The team, led by Lee Friedman of UIC's School of Public Health, looked at the records of about 1,100 people over the age of 60 who were discharged from hospitals in the Chicago area from 2007 to 2011. The majority had entered the hospital from home, while 49 came from assisted living communities, 369 lived in for-profit SNFs, and 61 lived in non-profits.

Friedman and the researchers then used an internally developed metric, the Clinical Signs of Neglect Scale, to assess whether the patients experienced harmful or abusive treatment leading up to their hospitalizations; the figure adds extra weight to diagnoses strongly associated with neglect, such as broken catheters or pressure ulcers, and puts less emphasis on dehydration and malnutrition — signs that are more weakly associated with likely neglect.

"Patients receiving care in for-profit institutions were diagnosed with substantially more clinical signs of neglect than patients residing in not-for-profit facilities and low-functioning, community-dwelling patients," the researchers concluded. "As reported in prior research, for-profit facilities caring for the patients in this study were significantly inferior across nearly all staffing, capacity, and deficiency measures."

In particular, "serious signs" of neglect were also more common among residents of for-profit facilities, including stage-three or four pressure ulcers and lack of access to medications aimed at managing chronic conditions.

Friedman and the team blamed pay disparity at for-profit SNFs for the findings.

"For-profit nursing facilities pay their high-level administrators more, and so the people actually providing the care are paid less than those working at nonprofit places," Friedman said in a release announcing the results. "So staff at for-profit facilities are underpaid and need to take care of more residents, which leads to low morale for staff, and it's the residents who suffer."

The UIC team also pointed out that the amount of for-profit nursing homes nationwide has increased over the last decade, while more non-profit and government-run entities have seen small declines. But they also acknowledged that nationwide, the overall number of nursing home beds has dropped — despite the fact that the population continues to age.

"For-profit facilities help fill this void and are important to the overall capacity needs nationwide, but adequate oversight needs to be in place to guarantee that an increase in capacity does not occur at the expense of quality of care," they concluded, adding that local enforcement agencies should receive appropriate staffing support and employees should receive quality assurance training.

U.S. Pays Billions for 'Assisted Living,' but What Does It Get? February 3, 2018

WASHINGTON — Federal investigators say they have found huge gaps in the regulation of assisted living facilities, a shortfall that they say has potentially jeopardized the care of hundreds of thousands of people served by the booming industry.

The federal government lacks even basic information about the quality of assisted living services provided to low-income people on Medicaid, the Government Accountability Office, a nonpartisan investigative arm of Congress, says in a report to be issued on Sunday.

Billions of dollars in government spending is flowing to the industry even as it operates under a patchwork of vague standards and limited supervision by federal and state authorities. States reported spending more than $10 billion a year in federal and state funds for assisted living services for more than 330,000 Medicaid beneficiaries, an average of more than $30,000 a person, the Government Accountability Office found in a survey of states.

States are supposed to keep track of cases involving the abuse, neglect, exploitation or unexplained death of Medicaid beneficiaries in assisted living facilities. But, the report said, more than half of the states were unable to provide information on the number or nature of such cases.

Occupational Injuries and Exposures among Emergency Medical Services Workers. July-Aug 2017

Prehospital Emergency Care: official journal of the National Association of EMS Physicians and the National Association of State EMS Directors

Abstract

OBJECTIVE:

Emergency medical services (EMS) workers incur occupational injuries at a higher rate than the general worker population. This study describes the circumstances of occupational injuries and exposures among EMS workers to guide injury prevention efforts.

METHODS:

The National Institute for Occupational Safety and Health collaborated with the National Highway Traffic Safety Administration to conduct a follow-back survey of injured EMS workers identified from a national sample of hospital emergency departments (EDs) from July 2010 through June 2014. The interviews captured demographic, employment, and injury event characteristics. The telephone interview data were weighted and are presented in the results as national estimates and rates.

RESULTS:

Sprains and strains accounted for over 40% of all injuries (37,000, 95% CI 22,000-52,000). Body motion injuries were the leading event (24,900, 95% CI 14,900-35,000), with 90% (20,500, 95% CI 12,800-32,100) attributed to lifting, carrying, or transferring a patient and/or equipment.

Exposures to harmful substances were the second leading event (24,400, 95% CI 11,700-37,100).

States with the Best Elder-Abuse Protections. December 4, 2018

Abuse happens every day and takes many forms. But vulnerable older Americans are among the easiest targets for this misconduct, especially those who are women, have disabilities and rely on others for care. By one estimate, elder abuse affects as many as 5 million people per year, and more than 95 percent of all cases go unreported.

Unless states take action to prevent further abuse, the problem will grow as America becomes an increasingly aging nation. The U.S. Census Bureau expects the population aged 65 and older to nearly double from 43.1 million in 2012 to 83.7 million in 2050, much to the credit of aging Baby Boomers who began turning 65 in 2011. And by just 2030, 1 in 5 U.S. residents will be retirement age.

Fortunately, states recognize that elder abuse is a real and growing issue. But sadly, only some are fighting hard enough to stop it. WalletHub compared the 50 states and the District of Columbia based on 14 key indicators of elder-abuse protection in 3 overall categories. Our data set ranges from "share of elder-abuse, gross-neglect and exploitation complaints" to "financial elder-abuse laws." Continue reading below for our findings, expert commentary and a full description of our methodology.

States with the Best Elder-Abuse Protections

Overall Rank (1=Best)	State
1	Massachusetts
2	Wisconsin
3	Nevada
4	Michigan
5	Arizona
6	Vermont
7	Iowa
8	Pennsylvania
9	North Carolina
10	West Virginia
40	Oregon
41	Utah
42	Idaho
43	Kentucky
44	New Mexico
45	Arkansas
46	South Dakota
47	Montana
48	California
49	New Jersey
50	Wyoming
51	South Carolina

DHS: SENIORS AND PEOPLE WITH DISABILITIES

Administrator Alert

Policy updates & rule clarifications for Assisted Living, Residential Care & Nursing Facilities

Office of Licensing & Quality — Oregon Department of Human Services

May 10, 2011

Emergency Response protocols for Assisted Living and Residential Care Facilities

The CBC News Hour in March was used to discuss the appropriate use of Emergency Medical Services (EMS) in assisted living and residential care facilities. We had guest speakers from various fire and rescue districts speak about the rising use of emergency services. This alert is a reminder of the information that was provided and the importance of proper utilization of this resource.

According to Steve Forster, Division Chief of Tualatin Valley Fire & Rescue, 80 percent of a fire department's workload is comprised of emergency response calls and one out of every four EMS calls comes from ALFs and RCFs. Falls are the single largest type of call from facilities and the greatest source of confusion and frustration for emergency responders and care providers alike. Emergency resources are limited and should be used judiciously and for emergency purposes only.

Assisted living and residential care facilities are required to have:

- Adequate staff to meet the scheduled and unscheduled needs of residents 24 hours a day;
- A licensed nurse that is regularly scheduled for onsite duties and available for telephone consultation;
- Evaluations and interventions in place for residents who are potential fall risks, or who may need the assistance of more than one staff member at any time.

Administrator Alert

Policy updates & rule clarifications for Assisted Living, Residential Care & Nursing Facilities

Office of Licensing & Quality — Oregon Department of Human Services

The intent and expectation for licensed assisted living and residential care facilities are:

- Facilities are expected to assist residents who have fallen and are not injured;
- Facilities are expected to evaluate a resident who experiences a significant change of condition and not use emergency responders to perform evaluations;
- If EMS is called for an emergency situation, there should be a staff available who is familiar with the resident's condition and provides accurate paperwork for transport with the resident;
- If a resident who is competent requests that EMS not be called and does not wish to be transported, the wishes of the resident should be respected and documented;
- If a resident is not competent to make his/her health care decisions, the facility should have paperwork indicating this to provide to EMS;

We strongly recommend that you contact your local fire department and emergency responders to discuss their specific recommendations and practices that will make their job and yours more efficient and safer for the community. Provide information to these agencies to educate them on your specific limitations and concerns. This will allow a better understanding and utilization of the resources that are available.

LONG-TERM CARE OMBUDSMAN PROGRAM

FACT SHEET

What You Must Know

WHAT IS THE LONG-TERM CARE OMBUDSMAN PROGRAM (LTCOP)?

Under the federal Older Americans Act (OAA) every state is required to have an Ombudsman Program that addresses complaints and advocates for improvements in the long-term care system.

Each state has an Office of the State Long-Term Care Ombudsman (Office), headed by a full-time State Long-Term Care Ombudsman (Ombudsman) who directs the program statewide. Across the nation, staff and thousands of volunteers are designated by State Ombudsmen as representatives to directly serve residents.

WHAT DOES THE OMBUDSMAN PROGRAM DO?

The Ombudsman program advocates for residents of nursing homes, board and care homes, assisted living facilities, and other similar adult care facilities. State Ombudsmen and their designated representatives work to resolve problems individual residents face and effect change at the local, state, and national levels to improve quality of care. In addition to identifying, investigating, and resolving complaints, **Ombudsman program responsibilities include:**

- Educating residents, their family and facility staff about residents' rights, good care practices, and similar long-term services and supports resources;
- Ensuring residents have regular and timely access to ombudsman services;
- Providing technical support for the development of resident and family councils;
- Advocating for changes to improve residents' quality of life and care;
- Providing information to the public regarding long-term care facilities and services, residents' rights, and legislative and policy issues;
- Representing resident interests before governmental agencies; and
- Seeking legal, administrative and other remedies to protect residents.

Ombudsman programs do not:

- Conduct licensing and regulatory inspections or investigations;
- Perform Adult Protective Services (APS) investigations; or
- Provide direct care for residents.

RESIDENTS' RIGHTS

Ombudsman programs help residents, family members, and others understand residents' rights and support residents in exercising their rights guaranteed by law. Most nursing homes participate in Medicare and Medicaid, and therefore must meet federal requirements, including facility responsibilities and residents' rights. For more information about residents' rights visit http://ltcombudsman.org/issues/residents-rights and http://theconsumervoice.org/issues/recipients/nursing-home-residents/residents-rights. Rights and care standards for assisted living/board and care facilities are regulated, licensed or certified at the state level.[1] For more information on assisted living visit http://ltcombudsman.org/assisted-living and http://theconsumervoice.org/issues/recipients/assisted-living. Regardless of the type of facility all residents have the right to be protected from abuse and mistreatment and facilities are required to ensure the safety of all residents and investigate reports of mistreatment.

[1] Some assisted living facilities provide services for residents receiving Medicaid benefits and must meet federal standards for that program.

Keck School of Medicine of USC
NCEA National Center on Elder Abuse
The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR
om buds man The National Long-Term Care Ombudsman Resource Center

FREQUENTLY ASKED QUESTIONS (FAQ)

Who does the Ombudsman program represent?

The Ombudsman program's mandate is to represent the resident and assist at his or her direction. The Older Americans Act (OAA) requires the Ombudsman program to have resident consent prior to investigating a complaint or referring a complaint to another agency. When someone other than the resident files a complaint, the ombudsman must determine, to the extent possible, what the resident wants.

What happens after I bring a concern to the Ombudsman program?

If someone other than a resident contacts the Ombudsman program with a complaint the ombudsman will visit the resident to see if the resident has similar concerns and wants to pursue the complaint. The ombudsman will explain the role of the program, the complaint investigation process, share information about residents' rights, ask about the resident's quality of life and care, and seek to understand the resident's capacity to make decisions. Many residents, even residents with dementia, are able to express their wishes. If the resident wants the ombudsman to act on the problem, the ombudsman will investigate the complaint and continue to communicate with the resident throughout the investigation process. If the resident cannot provide consent the ombudsman will work with the resident representative or follow program policies and procedures if the resident does not have a representative.[2]

What types of complaints does the Ombudsman program investigate?

Ombudsmen handle a variety of complaints about quality of life and care. Not all complaints are about the care provided by a facility, some complaints are about outside agencies, services or individuals (e.g., Medicaid or Medicare benefits). They can also receive and respond to complaints from individuals other than the resident (e.g. family member), but still need resident permission to investigate or share information.

Do ombudsmen investigate complaints involving allegations of abuse, neglect, and exploitation?

Yes. The Ombudsman program investigates and resolves complaints that "relate to action, inaction or decisions that may adversely affect the health, safety, welfare, or rights of the residents" and that includes complaints about abuse, neglect, and exploitation.[3] Ombudsmen are directed by resident goals for complaint resolution and limited by federal disclosure requirements. Therefore, the Ombudsman program's role in investigating allegations of abuse is unique and differs from other entities such as, adult protective services and state licensing and certification agencies. Ombudsman programs attempt to resolve complaints to the residents' satisfaction (including those regarding abuse) and do not gather evidence to substantiate that abuse occurred or to determine if a law or regulation was violated in order to enforce a penalty. If necessary, with resident consent or permission of the State Ombudsman if the resident can't consent and does not have a legal representative, the ombudsman will disclose resident-identifying information to the appropriate agency or agencies for regulatory oversight; protective services; access to administrative, legal, or other remedies; and/or law enforcement action about the alleged abuse, neglect or exploitation.[4]

Is the Ombudsman program required to report allegations of abuse?

There are strict federal requirements regarding disclosure of Ombudsman program information. Resident-identifying information cannot be disclosed without resident consent, the consent of the resident representative, or a court order. Therefore, these disclosure requirements prohibit Ombudsman programs from being mandatory reporters of suspected abuse.[5]

How do I find more information about the Ombudsman program and contact an ombudsman?

Visit the National Long-Term Care Ombudsman Resource Center (NORC) website (www.ltcombudsman.org) to learn more about the program. Locate an Ombudsman program by clicking "Visit Our Map."

[3] Older Americans Act of 1965. Section 712 (a)(3)(A)

[2,4,5] For more information about the program's role in responding to complaints, including allegations about abuse, see the Administration for Community Living's Frequently Asked Questions about the LTCO program http://www.aoa.acl.gov/AoA_Programs/OAA/resources/Faqs.aspx#Ombudsman and the National Ombudsman Resource Center (NORC) website http://ltcombudsman.org/issues/abuse-neglect-and-exploitation-in-long-term-care-facilities.

This fact sheet was completed in association with the National Consumer Voice for Quality Long-Term Care for the National Center on Elder Abuse situated at Keck School of Medicine of USC and is supported in part by a grant (No. 90AB0003-01-01) from the Administration on Aging (AOA), U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official Administration on Aging or DHHS policy.

TOP 10 COMPLAINTS BY TOPIC AND TYPE OF FACILITY

Last 12 months - October 1, 2017 - September 30, 2018

Top 10 Complaint Codes and Complaint Descriptions	Total Complaints Lodged	Distribution by Type of Facility			
		Nursing	Residential Care	Assisted Living	Adult Foster
19 DISCHARGE/EVICTION - PLANNING, NOTICE, PROCEDURE, IMPLEMENTATION	357	135	94	99	28
44 MEDICATIONS - ADMINISTRATION, ORGANIZATION	234	89	55	88	2
42 CARE PLAN/RESIDENT ASSESSMENT - INADEQUATE, FAILURE TO FOLLOW PLAN OR PHY	218	75	53	84	6
71 MENU - QUANTITY, QUALITY, VARIATION, CHOICE, CONDIMENTS, UTENSILS, MENU	203	73	52	69	9
26 DIGNITY, RESPECT - STAFF ATTITUDES	161	58	41	55	6
41 FAILURE TO RESPOND TO REQUESTS FOR ASSISTANCE	149	90	26	31	2
38 PERSONAL PROPERTY - LOST, STOLEN USED BY OTHERS, DESTROYED	139	51	43	37	8
36 BILLING/CHARGES - NOTICE, APPROVAL, QUESTIONABLE, ACCOUNTING WRONG OR DEI	133	22	46	56	7
66 RESIDENT CONFLICT, INCLUDING ROOMATES	125	40	42	40	2
97 SHORTAGE OF STAFF	115	31	40	42	2
Total of top 10 complaints	**1834**	**664**	**492**	**601**	**72**
Total of ALL complaints	**4,130**	**1,496**	**1,192**	**1,244**	**185**

About 2% (78 complaints) were referred to Adult Protective Services

Choosing an Assisted Living or Residential Care Facility in Oregon

Oregon Consumer Guide

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Table of contents

Choosing an assisted living or a residential care facility for you or your family member

Section A: Introduction

When looking for a care facility, selecting the right care setting can be overwhelming. This guide provides information and suggestions about choosing an assisted living (ALF) or residential care facility (RCF). Making an informed choice results in a better living experience.

ALFs and RCFs provide services to six or more adults and people with disabilities living in home-like settings. Each setting offers and coordinates services available on a 24-hour basis to meet the daily living, health and social needs of the people who live there. ALF and RCF settings provide person-centered care. Person-centered care values personal choice, dignity, privacy, individuality and independence. Residents are able to direct their care and participate in daily decisions.

The Oregon Department of Human Services (DHS) licenses and regulates assisted living and residential care settings. Some ALF and RCF settings offer memory care services in the same building or on a campus. Memory Care Communities (MCCs) must have a special licensing endorsement from DHS in addition to an ALF or RCF license. These communities are specifically designed for persons with a dementia diagnosis. For more information regarding MCCs, please see page 10 of this guide.

Upon request, all facilities must give you a written Consumer Information Statement (CIS). This CIS helps you compare the costs and services offered by each facility. You should always ask for a copy of the CIS when you visit a facility.

You can access this guide and the Facility Comparison Tool on the Oregon Department of Human Services website.

This guide: https://apps.state.or.us/Forms/Served/se9098.pdf

Facility comparison tool: https://apps.state.or.us/Forms/Served/se2000.pdf

The Consumer Information Statement (CIS) used to be called a Uniform Disclosure Statement or "UDS."

Section B: Who may need an assisted living or residential care facility?

ALFs and RCFs are for people who may need help with daily activities and tasks. These settings offer personal care services, 24-hour care staff, meals, medication management, health services and social activities.

Individuals move into ALF/RCF settings for more social interaction, to reduce their responsibilities, for safety and security, and for activities, health services and wellness offerings.

ALFs and RCFs have different types of licenses even though they offer very similar services. They have the same licensing rules for services and staffing, but the requirements for the physical design of the facility are different. There are additional rules that apply to endorsed Memory Care Communities. The main difference between ALF and RCF settings is whether they offer shared or private apartment spaces and rooms. All ALF residents have their own apartments with a small kitchen area and a private bathroom. Some RCFs may have residents share rooms, while others offer private rooms or apartments.

ALF and RCF settings are not nursing facilities. They do not offer continuous nursing care or complex therapy services provided by nursing and post-acute care rehabilitation facilities.

Licensing survey reports should be publicly posted. If you don't see a recent licensing survey, ask a staff member to tell you where it can be found.

Why are ALFs and RCFs licensed by the Department of Human Services?

Licensing is a way to monitor the quality of care residents receive in ALFs and RCFs. Licensed ALFs and RCFs must meet and maintain certain standards and are inspected every two years. (Current inspection reports are available at the facility.) A license is required for a facility to advertise and provide care and services as an ALF or RCF.

Other types of settings

Continuing Care Retirement Communities

Some settings are called Continuing Care Retirement Communities (CCRCs). CCRCs offer living options grouped on a campus and often include independent, assisted living residential care and nursing facilities. CCRCs must share a disclosure statement with consumers similar to the Consumer Information Statement.

Independent or non-licensed senior housing communities

Some senior housing settings may offer independent living option such as scheduled activities, housekeeping, meals and transportation services. Unlike ALFs and RCFs, these

communities do not provide help with activities of daily living, medication management or health care coordination. You can hire private caregivers to assist you in one of these settings.

These senior housing settings are not licensed by the Oregon Department of Human Services. They must follow Fair Housing Act and landlord tenant laws and federal housing requirements, if applicable. These facilities cannot use the terms "assisted living facility" or "residential care facility."

Adult foster/care homes

These are licensed single-family homes where staff provide care for up to five people and serve a range of needs in a home setting.

Nursing facilities

These facilities provide licensed 24-hour supervised nursing care. Caregivers must be certified nursing assistants. Nurses and certified nurse aids provide nutritional, therapeutic and personal care.

Section C: What services are provided?

All ALFs and RCFs must offer basic services.
These services include:

- 24-hour supervision
- Three meals a day in a group dining room
- Modified special diets (such as low salt and reduced or no added sugar, simple texture changes, pureed food)
- Personal care services (help with bathing, dressing, toileting, eating)
- Medication management
- Health care coordination by a nurse
- Recreational and spiritual activities
- Laundry and linen services, and/or washers and dryers
- Housekeeping and upkeep for your room or apartment
- Transportation coordination services
- Intermittent behavioral supports

The rules require all ALFs and RCFs to provide you with the assistance of a caregiver, if needed, to help you with all activities of daily living, such as bathing, using the toilet, and getting in and out of bed, 24 hours a day.

What additional services may be offered by ALFs and RCFs?

Some facilities provide more intensive health-related services. For example, a medically complex diet requires a registered dietician be involved in planning. Residents and their families should know what additional services the facility offers, and the costs and limits of those services. If the facility agrees to provide you with extra services, get that agreement in writing.

Consider what services you need now and what you may need in the future as you age and your health care needs changes. You will be more successful at choosing a facility if you match your needs with the setting that is the best fit for your current and future needs.

How can the facility help you with medications and nursing services?

Medication management

The majority of seniors living in ALF and RCF settings need help with their medications. Facilities are required to have safe medication systems and provide additional training to caregivers who give medications. Staff who typically administer medications are not nurses, but the medication system is approved by a registered nurse, physician or pharmacist.

To ensure safe delivery of medications, many ALFs and RCFs require medications to be "bubble packed" with each pill in a separate plastic bubble on top of a cardboard package. Your pharmacy needs to package your medications in the way the facility requires. If your family is going to bring in your medications, ask how the pills need to be packaged and what happens if the family is unable to bring the medications. This information should be included in the disclosure and residency agreements.

Medicare Part D or Medicaid programs may pay for all or some of your medications.

Nursing services

ALFs and RCFs are required to have a registered nurse (RN) on staff or on contract. In addition to a RN, some facilities also use licensed practical nurses (LPN). Nursing staff hours vary from facility to facility. The number of licensed nursing hours must be based upon the number of residents and their health service needs. The hours should also be included in the facility staffing plan.

Ask the administrator how many hours a week the nurse is in the facility.

The nurse typically does not give hands-on nursing care. The licensed nurse in an ALF and RCF oversees and coordinates your health service needs. Facility nurses will be involved in assessing and updating your service plan if there is a major change in your health condition or other nursing needs.

Who are the caregivers at these settings?

Caregivers will have different tasks at each facility. Oregon rules require all caregivers receive orientation and training and demonstrate competency before working with residents. Each caregiver receives 12 hours of additional training every year plus additional fire and life safety training.

Outside provider services

The facility must help residents in accessing health care services and benefits to which they are entitled from outside providers. The facility must also coordinate onsite health services with outside service providers such as hospice, home health or other privately paid supplemental health care providers. Residents do have the choice of coordinating their own medical appointments, but they need to communicate that information to the facility.

How will you know if there are enough staff members to care for you and the other residents?

Oregon rules require ALFs and RCFs to develop "acuity-based" staffing plans. This means each facility must have a written system to determine the appropriate number of caregivers needed to meet their residents' needs. Facilities must be able to explain how their system works and are required to adjust staffing needs when residents' needs change. They are required to have enough staff to meet the scheduled and unscheduled needs of the residents living in their facility. An example of an unscheduled need would be if you required additional help because of a sudden illness or injury.

> Facilities must post a staffing plan. Look at the plan and ask how it is adjusted to meet the changing needs of the residents.

What kind of meal services will you get?

Facilities are required to serve three nutritious meals and snacks each day. Meals should vary and should include seasonal fresh fruits and vegetables. When planning the menus, the facility should take into consideration what the residents like to eat and involve residents in menu planning.

> If you require a special diet, be sure to ask for an explanation of how the facility can meet your need.

Facilities are not required to have a registered dietitian on staff although many use a dietician to plan menus. In addition to the modified diets that the facility provides, such as low salt or reduced sugar, some facilities may provide more complex doctor-ordered diets.

What activities are available for you?

Facilities are required to provide a variety of daily activities. They must ask you about your activity preferences and include those in your service plan. These planned activities must offer opportunities to be involved in the larger community, outside of the facility.

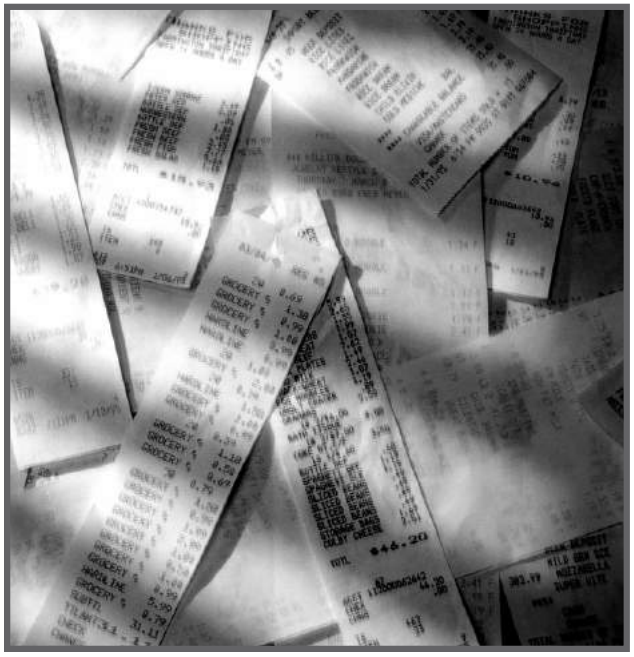
ALFs and RCFs must provide equal services to residents with disabilities. If you use a wheelchair or other mobility aid, ask how your needs will be accommodated during outings. If the ALF or RCF has its own van, ask how many wheelchair spaces are available and how they determine who gets to go on an outing.

Fire and other safety considerations

Ask the facility how staff will respond if there is a fire or some other crisis. Facilities are required to conduct routine fire drills and have emergency plans. The emergency plan must include responses to different types of emergencies and address the medical needs of the residents. Evacuation plans should be posted throughout the facility and specific evacuation instructions must be supplied to you upon admission to the facility.

In an emergency you may need to be able to leave the facility on your own or with staff help. Facility staff will show you how and when to exit as part of your orientation.

Section D: Information regarding cost of care



Costs for ALFs and RCFs vary greatly, depending on the size of rooms, amenities and services provided. Calculating how much it might cost is important, as is understanding what increases might occur after you move in.

Compare the costs of each facility

Facilities should give you information about their rates and any specific fees for extra services. Consider this information when choosing the right setting.

Some cost information can be found in the Consumer Information Statement and more complete cost information is in the facility's residency agreement.

Here are some questions to ask about the costs:

- What are the services covered in the fee? What is extra?
- What is the range of costs?
  Ask the facility what are the lowest, highest and average monthly charges.
- Should I expect the fees to increase each year?
  Most facilities raise their rates 3–5 percent each year due to increasing costs. Ask what the facility's history of rate increases have been over the last two or three years.
- How can I compare fee arrangements?

  It can be hard to compare the different fee arrangements at each facility. Facilities charge for their services in a variety of ways. The cost will vary based on the particular residence, size and features of the apartment/living unit, the amount of amenities, and the level of services you need. There may be additional charges such as entrance fees and deposits. Most have a base rate that usually covers the cost of room and board, housekeeping and activities, and may include some amount of personal care.

  Sometimes the terms used by facilities to bill for care and services may not be clear. You may come across terms such as "levels of care" or "point system" or a combination of points and level of care. Facilities may use a different system and it is important for you to understand how the facility bills for their services. Below is an explanation of the most common billing methods.

Point system – All care-giving services, such as helping you with bathing, dressing and getting on and off the toilet, are given a number of points based on how much time the facility believes it will take the staff to help you. Each facility assigns a dollar amount to its points. After the facility has decided how much care you will need, it adds up the number of points and multiplies that total by the dollar amount it has assigned to each point. This is the amount you are charged for the services you are given. For example, if you need assistance with medication administration, you might be assigned a higher number of points if the medication has to be provided more than one time per day. The higher number of points may increase your charge.

Advantage: You are charged for the services you actually want or need.

Disadvantage: The amount you are charged can change from month to month.

Level system – or a tier system. A typical set of services are set for each 'level." Lower levels equal less or less-intensive services; as the levels increase so do the services and cost. For example, you might start out at level one and do most things for yourself. As time goes by you need help to get dressed and showered. You would then move to another level and be charged more money.

Advantage: You can easily tell how much you are going to be charged based on the care you need.

Disadvantage: There is less flexibility. As soon as you need at least one service in the next level, you can be charged at that level's rate.

Bundled points and level of care – All care-giving services are given a number of points based on how much time the care facility believes it will take the staff to help you. Each level contains an amount of points assigned by the facility. For example, a facility may decide that people who need 1–20 points of care are in level one. Those who need 21–30 points of care will be in level two. Those in level two will be charged more than those in level one.

Advantage: This system allows for small changes for services needed without necessarily changing the rate.

Disadvantage: If you are on the lower end of the level, you are paying the same rate as someone at the higher end of the level.

In summary:

- Ask the administrator to explain the method of deciding monthly charges.
- In general, the more services you need, the higher your monthly cost.
- Even if you don't need many services now, you may need more in the future and your monthly costs may increase.

Oregon has a website called the **Aging and Disability Resource Connection (ADRC)**. The ADRC website has information on funding your care. The website has tools to calculate how much ALF and RCF services will cost and how to estimate your available financial resources.

ADRC website: https://adrcoforegon.org/consite/plan-funding-your-care.php

Medicaid long-term care services - There are several programs that may provide assistance, each with different eligibility criteria. Medicaid pays for ALF and RCF services for eligible, low-income individuals. Your need for services and your income are evaluated to determine eligibility.

There are several insurance and government programs that could help you pay for ALF and RCF services. These programs may cover some of your future costs.

Long-term care insurance: Will long-term care insurance cover all or part of the costs?

Some private health and long-term care insurance policies include coverage for ALF and RCF care. If you have an insurance policy, check with your agent to find out exactly what the policy will cover and how you will be screened to find out if your health condition is eligible for coverage. Ask your agent if the benefit will cover the facility service fees.

Medicare: Will Medicare cover the cost of care?

No, Medicare does not cover the cost of living in an ALF or RCF facility.

Medicaid: Does the facility accept Medicaid payments for their services? If so, are you eligible for services?

Many, but not all, facilities accept Medicaid as a source of payment. If you think you may not have enough money for care in an ALF or RCF setting, you should call your local Department of Human Services, Aging and People with Disabilities office or the Area Agency on Aging. The staff can check to see if you are eligible for Medicaid long-term care or other state services.

Medicare doesn't pay for ALF and RCF care. Medicare will help pay for a limited amount of skilled nursing or home health care if you meet certain conditions in connection with a hospital stay.

They will also explain how you will use your income (Social Security, pension, etc.) to help pay for services. The facility cannot charge you more than the amount Medicaid had calculated as your contribution towards your care. Medicaid provides for a small personal incidental fund allowance to cover items you choose to buy for yourself.

Facilities who accept Medicaid cannot require you to pay out of your own resources for a set length of time. For example, they should not be able to say that you must be able to pay privately for six months before going on Medicaid. These "duration of stay" contracts are not enforceable. Call the Long-Term Care Ombudsman's Office at 1-800-522-2602 if you are told you must pay privately for a specific period of time.

Section E: Why might you need an ALF or RCF?

First, look at what care and services you may need. Assess your current physical status and health care needs. Do you need help to bathe, dress, groom, eat, shop, get from place to place or manage your medications?

Next consider what your needs may be in the future? Could your care needs improve with additional support and assistance or decline due to a health condition?

Finally, look for a facility that can provide the services you need now and ones that you may need in the future.

Look at the facility description and the services provided. Pick the one that best matches your current and future needs.

Section F: How do you choose the right facility?

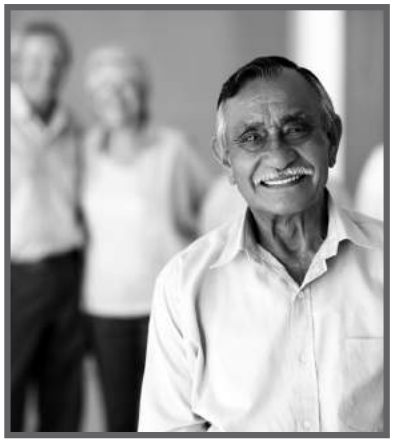
After looking at the care and services that you may need, how do you find the right setting? Start by deciding what ZIP code or area you want to live within.

You can search the many online sites to help you look for a facility. Oregon's ADRC website can help you find a facility close to your home by using a ZIP code search. See https://adrcoforegon.org/consite/index.php and the list of additional resources at the end of this guide on page 15. Call the facilities that interest you to arrange a visit.

The Long-Term Care Ombudsman office can also provide you with a list of facilities near your home, review facility complaint files and guide you to the type of setting that may be most appropriate for you. Call 1-800-522-2602.

You may not have much time to look for a setting if you are leaving a hospital or nursing facility after an injury or illness. The social worker or discharge planner may give you a list of facilities to choose from. If you are eligible for Medicaid, your case manager will help you find a facility.

Section G: Endorsed Memory Care Communities



Specialized communities for persons with dementia are called Memory Care Communities (MCCs). These communities must have a DHS licensing endorsement in addition to an ALF or RCF license. MCCs must follow other rules specific to the care and services for people with dementia. MCC caregivers are provided with special training to better serve people with dementia.

MCCs may be part of another building, or they may be free standing communities. These settings provide space for people to walk either indoors or within the confines of a secured outdoor courtyard. Residents are encouraged to bring personal items such as bedding and pictures to make their rooms feel more like home.

In addition to providing services required by other licensed settings, endorsed MCCs must also have programs which include individualized nutritional plans, activities, support for behavioral symptoms and family support.

Section H: Choosing a facility

Choosing the right facility requires you to identify your needs and preferences and match them with the setting and services the facility provides. It is important for you to:

- Collect information on facilities.
- Tour the facilities and narrow your choices. Talk with residents, families and staff at each community you tour.
- Consider other factors, such as whether the facility can honor your food preferences and whether you can maintain your preferred morning and nighttime routines.
- Think about whether the facility can meet any future health needs based on your health status.
- Think about what kind of living space you are looking for.
- Compare facility services and costs.
- Ask about why you may have to move out of a facility.

When choosing a facility, it is important that you understand the sections of the residency agreement related to moving out and refunds. That way, you will know what to expect if you decide to move out.

Use the CIS, facility visits, the ALF/RCF consumer comparative tool and other methods to help you decide which facility best meets your needs.

Section I: Preparing for your move in

What should you expect before you move into a facility?

Before moving into a facility, you may be asked to complete some tasks and fill out forms and agreements.

1. **The application form and selected financial information**

   A facility may have you fill out an application form. You may also be asked to give detailed financial information about your assets, savings and earnings. Facilities financed with government housing dollars are required by law to have detailed financial information from you. If you do not wish to give out this information, you may be able to find a facility that does not require it.

   Facilities use the financial information to be sure you have the ability to pay for services. It can also alert them that you may be eligible for Medicaid-funded services.

2. **Additional legal and medical information**

   Before move-in, the facility will ask you for copies of any of the following documents you may have completed:

- Advance directive
- Guardianship
- Conservatorship
- Power of attorney
- Any other legal document that may affect your future care

The facility will also request information about your medical history and will require any current orders from your doctor, including orders for your medications. The facility cannot administer your medications without the order from your doctor.

3. **An in-person visit**

   Facility staff will talk with you to get to know you and your care needs. Based on your situation, the facility may ask to come to your home to evaluate your care needs before you move into the facility. Staff will also ask about what kind of activities interest you. You may want to include your family and friends in the visit and information gathering process. Including family may be important if you have memory problems or a complex medical history. The information discussed during this visit will help the facility staff decide whether or not they can meet your needs.

4. **The initial service plan**

   The facility will develop an initial service plan for you that will most likely change within the first month of living in your new facility as the staff get to know you better.

5. **Residency agreement**

   The residency agreement is a legal contract signed by you and the facility. It is one of the most important documents you will receive. You should understand the terms of the agreement and keep a copy for your records.

The residency agreement should have information on these important topics:

1. All required fees and deposits
2. Any services the facility offers or does not offer
3. The facility can only change your rate if:
   - You are given written notice at least 30 days in advance of a facility-wide increase.
   - Your care needs and service plan change, and the facility provides you with immediate written

The residency agreement is your contract with the facility. Read it carefully and if you don't understand it, contact an attorney or the Long-Term Care Ombudsman's Office. (See page 15.)

notice of an increase.

4. The refund policy if you leave voluntarily or are given a move-out notice
5. The "move-out" criteria that explains why you may need to move out of the facility
6. Other important legal rights
7. Successful transitions guide (https://apps.state.or.us/Forms/Served/de9566.pdf)

What is a service plan and why is it important?

A service plan is the tool used to let caregivers know what care and services you need. Facility staff will evaluate your care needs and work with you to create a service plan. A basic service plan must be developed before you move in. The facility should review your service plan with you every three months, or as needed if your health changes significantly, to make sure your needs are being met. Your written service plan should always reflect your most current needs and preferences.

You should take an active role in this service planning process. You can have family and friends involved. The ALF or RCF will remind you when it is time for the meeting and work with you to pick a convenient date and time. Remember the amount or type of services listed in the service plan will most often affect how much you are charged each month.

Section J: What are your rights and responsibilities as a resident?

You must be given a copy of your rights before moving into the facility. You may be asked to sign a statement that you agree to follow the facility guidelines. These guidelines should never interfere with your legal rights. Getting this information in advance can be helpful in deciding if a certain facility is the right place for you.

The Residents' Bill of Rights can be found on page 16.

Facilities have a grievance process to address your complaints and those of other residents. Most facilities have a resident council and/or a family council that meet regularly to talk about these concerns.

Oregon rules set out a detailed list of resident's rights. Ask the administrator if you have any questions or concerns about your rights in a facility care setting, and/or call the Long-Term Care Ombudsman. (See page 15.)

Facilities may have a "code of conduct" or a list of "responsibilities of residents" as part of a resident handbook. Some of these guidelines are for your safety and others are designed to create a living situation that supports respect and dignity. For example, you may not be able to have a pet or keep guns at the facility.

Section K: Moving out of a facility

ALFs and RCFs may ask a resident to move out for reasons outlined by Oregon Administrative Rules. For example, your care needs may change to the point the facility can no longer meet them. You may need hospital or nursing facility care after a severe stroke. Reasons a facility may ask you to move out are included in the residency agreement you will sign when you move in.

You must be given written notice if a facility asks you to move out. The notice will have information about your right to object to the move, the right to request an informal meeting with the Oregon Department of Human Services and your right to request a hearing. The informal meeting is an attempt to resolve the matter before a hearing.

The situations below describe some reasons you could be asked to move out of a facility. Ask the facility if any of these might cause them to request that you move out:

1. I need two people to help transfer me, for example, from my wheelchair to my bed.
2. I need help because of dementia.
3. I need or want a special diet, for example a renal diet.
4. I need help monitoring and managing my diabetes.

Oregon encourages facilities to support a resident's choice to remain in his or her living environment while recognizing that some residents may no longer be appropriate for the facility due to safety and medical limitation.

Section L: For more information about these facilities

If you would like more information about ALFs and RCFs:

1. Additional tips for choosing your ALF or RCF are available at https://adrcoforegon.org/consite/index.php or call 1-855-673-2372 (1-855- ORE-ADRC).
2. The Department of Human Services website has a Facility Comparison Tool for choosing among Oregon's assisted living and residential care facilities. https://apps.state.or.us/Forms/Served/se2000.pdf

3. You can call the Department of Human Services licensing unit at 1-800-282-8096.
4. You can call the Long-Term Care Ombudsman office at 503-378-6533 or 1-800-522-2602. The office of the Long-Term Care Ombudsman is a free service available to residents, families, facility staff and the general public. Ombudsman respond to a wide variety of resident concerns, including problems with resident care, medications, billing, lost property, meal quality, evictions, guardianships and service plans.
5. You can check the Care Conversations website at https://careconversations.org/.
6. These Oregon long-term care associations have consumer information on their websites:
   Oregon Health Care Association - http://www.ohca.com
   Leading Age Oregon - http://www.leadingageoregon.org

Section M: Residents' Bill of Rights

The facility must implement a Residents' Bill of Rights. Each resident and the resident's designated representative, if appropriate, must be given a copy of the resident's rights and responsibilities before moving into the facility. The Bill of Rights must state that residents have the right:

- To be treated with dignity and respect.
- To be given informed choice and opportunity to select or refuse service and to accept responsibility for the consequences.
- To participate in the development of their initial service plan and any revisions or updates at the time those changes are made.
- To receive information about the method for evaluating their service needs and assessing costs for the services provided.
- To exercise individual rights that do not infringe upon the rights or safety of others.
- To be free from neglect, financial exploitation, verbal, mental, physical, or sexual abuse.
- To receive services in a manner that protects privacy and dignity.
- To have prompt access to review all of their records and to purchase photocopies. Photocopied records must be promptly provided, but in no case require more than two business days (excluding Saturday, Sunday, and holidays).
- To have medical and other records kept confidential except as otherwise provided by law.
- To associate and communicate privately with any individual of choice, to send and receive personal mail unopened, and to have reasonable access to the private use of a telephone.
- To be free from physical restraints and inappropriate use of psychoactive medications.
- To manage personal financial affairs unless legally restricted.
- To have access to, and participate in, social activities.
- To be encouraged and assisted to exercise rights as a citizen.
- To be free of any written contract or agreement language with the facility that purports to waive their rights or the facility's liability for negligence.
- To voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of retaliation.

- To be free of retaliation after they have exercised their rights
- To have a safe and homelike environment.
- To be free of discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.
- To receive proper notification if requested to move-out of the facility, and to be required to move-out only for reasons stated in OAR 411-054-0080 (Involuntary Move-out Criteria) and have the opportunity for an administrative hearing, if applicable.

In addition to the rights listed above, there are additional federal rights for assisted living and residential care facilities that are considered home- and community-based settings (HCBS).

(2) HCBS RIGHTS.

(a) Effective Jan. 1, 2016 for providers initially licensed after Jan. 1, 2016, and effective no later than Sept. 1, 2018 for providers initially licensed before Jan. 1, 2016 the following rights must include the freedoms authorized by 42 CFR 441.301(c)(4) and 42 CFR 441.530(a)(1):

(A) Live under a legally enforceable residency agreement;

(B) The freedom and support to access food at any time;

(C) To have visitors of the resident's choosing at any time;

(D) Choose a roommate when sharing a bedroom;

(E) Furnish and decorate the resident's bedroom according to the Residency Agreement; and

(F) The freedom and support to control the resident's schedule and activities.

500 Summer Street NE, E12
Salem, OR 97301-1073
Hours: 8:00 a.m. - 5:00 p.m.
Email: spd.web@state.or.us
503-945-5921
1-800-282-8096
TTY: 800-282-8096

You can get this document in other languages, large print, braille or a format you prefer. Contact Aging and People with Disabilities at 503-945-5921 or 1-800-282-8096 or email spd.web@state.or.us. We accept all relay calls or you can dial 711.

DHS 9098 (rev 10/2016)