SAFETY, OVERSIGHT, AND QUALITY UNIT

February 2025 Rapid Response Report

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I. Executive Summary

This rapid response report, conducted by Alvarez and Marsal (A&M), evaluates the alignment of the Safety, Oversight, and Quality (SOQ) unit within the Oregon Department of Human Services (ODHS) with state requirements. To complete this assessment, A&M employed a multi-faceted approach, including detailed statutory reviews, interviews, and focus groups to gather comprehensive insights into the SOQ unit's operations. The project spans several months, with this Rapid Response Report serving as the first of three deliverables that will evaluate and make recommendations for the SOQ unit. The SOQ unit's role in safeguarding the health and safety of residents in nursing homes and other long-term care settings is critical, and this report highlights areas where improvements are necessary to enhance its effectiveness.

A&M identified several areas of misalignment between state statutory expectations and SOQ practice. The evaluation revealed significant discrepancies in the timeliness of licensing and renewal surveys, particularly within the CBC unit, which does not meet state-mandated timelines. Both the NF and CBC units struggle to initiate and complete complaint investigations within the state-mandated response times, with a backlog exacerbated by the COVID-19 pandemic. This backlog may also create conditions for compliance issues that arise due to delays in surveys. Inconsistencies in enforcement and corrective actions within the CBC unit, reliance on informal corrective measures, and the influence of individual staff discretion further complicate regulatory practices. Additionally, overlapping and ambiguous statutory mandates create operational complexities that hinder the unit's ability to act consistently.

To address these challenges, A&M recommends a suite of short and longer-term recommendations, including things like implementing process efficiencies and investing in temporary staffing resources to clear the backlog of surveys and complaints. Legislative actions, such as removing requirements for licensee agreement in regulatory enforcement actions and clarifying expectations for licensing suspension and interim management procedures (when SOQ determines that new leadership of a facility is required for the safety of its residents) will

strengthen the SOQ unit's regulatory authority and operational clarity. Reviewing and updating the civil penalty structure will ensure that penalties serve as an effective deterrent against noncompliance.

The SOQ unit's work is paramount to the safety and well-being of residents in Oregon's long-term care facilities. Addressing the identified misalignments through policy revisions, increased staffing, and legislative changes will enhance the unit's capacity to protect residents and ensure compliance with state requirements. This report underscores the critical importance of SOQ's role and the urgent need for targeted interventions to support its mission.

The report is structured as follows: Section 1 provides an executive summary of the report. Section 2 introduces an overview of the SOQ unit and its responsibilities. Section 3 outlines acronyms and definitions utilized in the report. Section 4 details A&M's data and approach. Section 5 provides a high-level overview of the federal policy landscape that impacts SOQ. Section 6 includes A&M's findings related to operational alignment with legislative mandates. Section 7 presents A&M recommendations.

II. Organizational Context

The SOQ (Safety, Oversight and Quality) unit falls within the Office of Aging and People with Disabilities (APD), which is one of six programs under the umbrella of the Oregon Department of Human Services (ODHS). SOQ is charged with licensing and regulatory oversight of long-term care settings that serve older adults and people with physical disabilities. These responsibilities include reviewing initial licensing applications and license renewals. Long-term care settings include adult foster homes, nursing home facilities, residential care facilities, assisted living facilities, and facilities that have completed the additional requirements to provide memory care for people with dementia or intensive intervention for people with behavioral health conditions. In its regulatory role, SOQ is required to conduct facility inspections (licensing surveys) at mandated intervals to assess licensing rule compliance for license renewal. The unit is also responsible for triaging, processing and investigating complaints in long-term care settings. When a facility is found to be out of compliance with applicable state or federal statutes, SOQ is responsible for taking action to compel the facility to comply. The nature of the intervention or corrective action depends on the scope, severity, and history of noncompliance and includes technical assistance, civil penalties, restrictive license conditions, facility oversight and supervision, or suspension, revocation, or non-renewal of a site's license.

Three sub-units, verticals, that specialize in a certain facility type, are responsible for completing SOQ's work.

- **Nursing Facility Survey Unit (NFSU or NF).** NFSU is responsible for licensing and regulatory oversight of Nursing Facilities (NF), which provide 24-hour supervised nursing care. Caregivers in licensed nursing facilities must be certified as nursing assistants and a licensed charge nurse must be present at each shift 24 hours a day (OAR 411-086-0100 (4)(e).
  NF may provide short-term stays following hospitalization or long-term care. NFSU is the designated State Survey Agency for the Centers for Medicare & Medicaid Services (CMS) responsible for the regulatory oversight of nursing facilities. While oversight of nursing facilities is primarily driven by CMS

requirements, Oregon also has state regulations that provide more stringent requirements than federal regulations in some instances, most notably related to requirements that ODHS commence investigations of facilities within certain timeframes depending on the severity of the complaint (ORS 441.650). Facilities are inspected for compliance with federal and state regulations approximately every 12 months. In addition to licensing compliance, NFSU investigates reported incidents of abuse in Nursing Facilities.[1]

- **Adult Foster Homes (AFH) Unit.** AFH unit is responsible for regulatory oversight – but not licensing – for Adult Foster Homes, which are single-family residences that offer 24-hour care in a homelike setting to five or fewer individuals. Local APD offices and Area Agency on Aging Offices (AAA's) are responsible for licensing AFH, except in Multnomah County, which is statutorily designated as its own independent licensing authority, allowing them to promulgate their own OARs for AFH.[2] Licensing visits conducted by APD local office or AAA licensors can include renewal/monitoring, complaint investigation, corrective action oversight, and other check-ins as needed. AFH rules (OAR 411-050) and Home- and Community-Based Services (HCBS) rules (OAR 411-004) govern Adult Foster Home standards of operations and federal HCBS standards protect residents' rights and freedoms. Inspections are conducted annually.
- **Community-Based Care (CBC) Unit.** CBC is responsible for licensing and regulatory oversight of Assisted Living and Residential Care Facilities, including those with an endorsement to provide memory care for people with dementia or intensive intervention for people with behavioral health conditions. Community-Based Care facilities are inspected for license renewal every 24 months and annually for kitchen inspections. CBC is

[1] "Aging & People with Disabilities Safety, Oversight and Quality Unit Survey/ Regulatory Overview," Joint Task Force on Hospital Discharge Challenges May 2024,
https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283944

[2] Multnomah County must at minimum meet the state standards for AFH. (MCAR – 023, https://multco.us/file/multnomah_county_administrative_rules_%28mcar%29/download)

primarily governed by Oregon Administrative Rules, specifically OAR 411-054, 411-055 and 411-057.[3]

Additionally, the SOQ team has a subunit that provides unit-wide operations support: **SOQ Operations.** The Operations team is responsible for providing support to the rest of SOQ including quality assurance, quality improvement, data reporting, oversight of SOQ policies and procedures, and the management of the licensing management system (CALMS).

SOQ operates within an ecosystem of entities that, like SOQ, are working to protect the health, welfare, and safety of residents in long-term care facilities in Oregon. These agencies play varying roles. The following bullets describe the key agencies working to support long-term care quality.

- **Adult Protective Services (APS).** APS is a unit with the ODHS/APD program and is distinct from SOQ. APS is responsible for investigating abuse complaints when the complainant's concern is related to abuse in a community setting (that is, outside of a LTC facility), in Adult Foster Homes, in Community-Based Care facilities, or in a nursing facility when a community member is involved (i.e., family or friend outside of the facility). APS investigators are based in local APD or Area Agency on Aging (AAA) offices across the state, which facilitates their ability to access sites quickly. When investigating abuse that took place in a licensed facility, APS investigators examine whether a facility's action or inaction contributed to the alleged abuse or risk of serious harm. The APS investigator sends a complaint investigation report to SOQ for issuing corrective action related to any substantiated allegations of abuse or neglect. SOQ also determines if a licensing violation occurred.[4]

[3] "Compliance Framework Guide: Community-Based Care (Residential Care and Assisted Living," Oregon Department of Human Services, Accessed December 2024, https://www.oregon.gov/odhs/licensing/community-based-care/Documents/cbc-regulatory-compliance-framework-guide.pdf.

[4] "Compliance Framework Guide: Community-Based Care (Residential Care and Assisted Living," Oregon Department of Human Services, Accessed December 2024, https://www.oregon.gov/odhs/licensing/community-based-care/Documents/cbc-regulatory-compliance-framework-guide.pdf.

- **Long-Term Care Ombudsman (LTCO).** The LTCO is an independent state agency that supports long-term care facility residents through complaint investigation, resolution and advocacy for improvement in resident care. Complaints are investigated and resolved by staff and trained and certified volunteer ombudsmen assigned to facilities throughout the state. Each certified volunteer ombudsman has legislative authority to enter into a long-term care facility and approach staff and residents without restriction to fulfill the LTCO mission. Ombudsmen are lawfully obligated to investigate all complaints referred by residents or on their behalf [ORS 441.109 (i)], monitor all government policies and actions that affect residents; protect and promote patients' rights [ORS 441.127 (e)], and keep residents and providers informed of the Program's objectives and concerns [ORS 441.127 (d)], as well as undertake any other legal action that promotes resident welfare as specified [ORS 441.127 (f)]. Whenever possible, certified ombudsmen try to solve problems informally with the appropriate, lowest level of facility management, while higher levels of management are involved if necessary. A provider's inability or unwillingness to solve the problem at the facility level results in a direct ombudsman request for corrective action from SOQ or a referral to APS for investigation and follow-up enforcement action if necessary.[5] [6]
- **Case Managers:** Case managers in Home and Community-Based Services (HCBS) perform several important activities to help ensure quality care. They serve as key points of contact for individuals, facilitating communication between clients, families, and service providers. By engaging in person-centered planning, case managers help develop care plans that are tailored to the unique needs and preferences of each individual. Additionally, they provide oversight on residential placements, regularly checking in to monitor the quality of care and address any issues

[5] Office of the Long-Term Care Ombudsman, "Certified Ombudsman Volunteer Position Description," Office of the Long-Term Care Ombudsman, Accessed December 2024, https://ltcombudsman.org/uploads/files/support/or--vol-description.pdf

[6] "Long-Term Care Ombusdsman: About Us," Office of the Long-term Care Ombudsman, Accessed December 2024, https://www.oltco.org/programs/ltco-about-us.html.

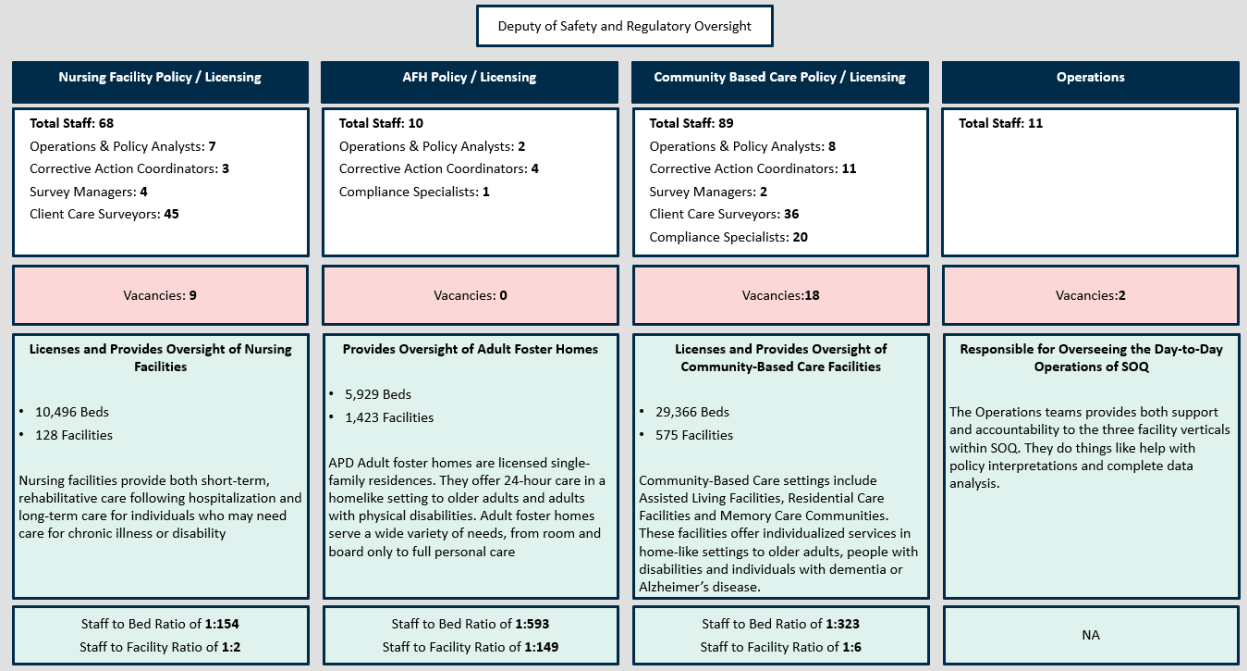
that may arise. This ongoing involvement helps to ensure that individuals receive consistent, high-quality support in their living environments.

- **External Organizations:** Provider associations such as LeadingAge Oregon and Oregon Health Care Association (OHCA), consumer advocacy groups such as the Governor's Commission on Senior Services (GCSS) and Disability Rights Oregon. These organizations work with SOQ and other policy makers to pursue system changes to support their interests. They provide valuable feedback about the day-to-day impacts of SOQ's implementation of its statutory requirements.

Together, these various entities work to promote stability and quality for residents of long-term care facilities in Oregon. While SOQ is an important piece of the overall effort, SOQ alone does not determine the efficacy of the system which is dependent on interventions across the community, advocates, and multiple units of government.

Figure 1. SOQ organizational summary with positions and facility scope shows a graphic representation of how SOQ is organized, along with the number of staff that are currently employed to manage the corresponding facility volume within each sub-unit. Comparatively, nursing facility licensing is the most well-resourced, with CBC managing over four times the number of facilities that NF does, with only 1.3 times the number of staff. Across SOQ, there is a current vacancy rate of 29, 16% of total allocated positions. Almost two-thirds of the current vacancies are in CBC.

Figure 1. SOQ organizational summary with positions and facility scope



III. Acronyms & Definitions

Many acronyms and specialized terms are included in this report. Included in this section is a list of the most common ones.

A&M: Alvarez & Marsal
ABST: Acuity-Based Staffing Tool
ADL: Assistance with Daily Living
AFH: Adult Foster Homes
APD: Aging and People with Disabilities Program
APS: Adult Protective Services
CAC: Corrective Action Coordinators
CBC: Community-Based Care
CMS: Centers for Medicare & Medicaid Services
HCBS: Home and Community-Based Services
IJ: Immediate Jeopardy
Licensing Suspension: Temporary withdrawal by ODHS of an agencies authorization to operate a specific setting or program
LCU: Licensing Complaint Unit
LOAs: Letters of Agreement
LTCO: Long-Term Care Ombudsman
NF: Nursing Facilities
NFSU: Nursing Facility Survey Unit
OAR: Oregon Administrative Rule
ODHS: Oregon Department of Human Services
OPAs: Operations & Policy Analyst
ORS: Oregon Revised Statutes
PACE: Program for All-Inclusive Care for the Elderly
SOQ: Safety, Oversight and Quality Unit
SWOT: Strengths, Weaknesses, Opportunities, and Threats

IV. Data & Approach

To complete this Rapid Response Report, the A&M team analyzed 6 types of information.

- **Interviews and Focus Groups.** In December and January of 2024, A&M completed informational interviews with approximately 50 people. Three focus groups were also held. A&M coded the interview notes and aggregated themes into findings based on prevalence.
- **Oregon Revised Statutes.** A&M completed a detailed review of ORS 441 & ORS 443, cataloguing and categorizing included mandates and authorities related to facility management.
- **Oregon Administrative Rules.** A&M completed a summary review of 26 OARs from OAR Chapter 411.
- **SOQ Unit Policies and Procedures.** A&M summarized and catalogued 64 SOQ policy and procedure documents related to the facility oversight as managed by NFSU, AFH Unit, and CBC.
- **SOQ Unit Training Materials.** A&M completed a detailed review of 16 training related documents provided by SOQ staff.
- **SOQ Unit Position Descriptions.** A&M summarized and catalogued 28 position descriptions for SOQ job roles.

This information was summarized and entered into tables that included operational area categorization. A&M used this classification information to compare information across information source. Interview information, based on prevalence, was used to identify key areas of interest which A&M then explored further, using the collected information.

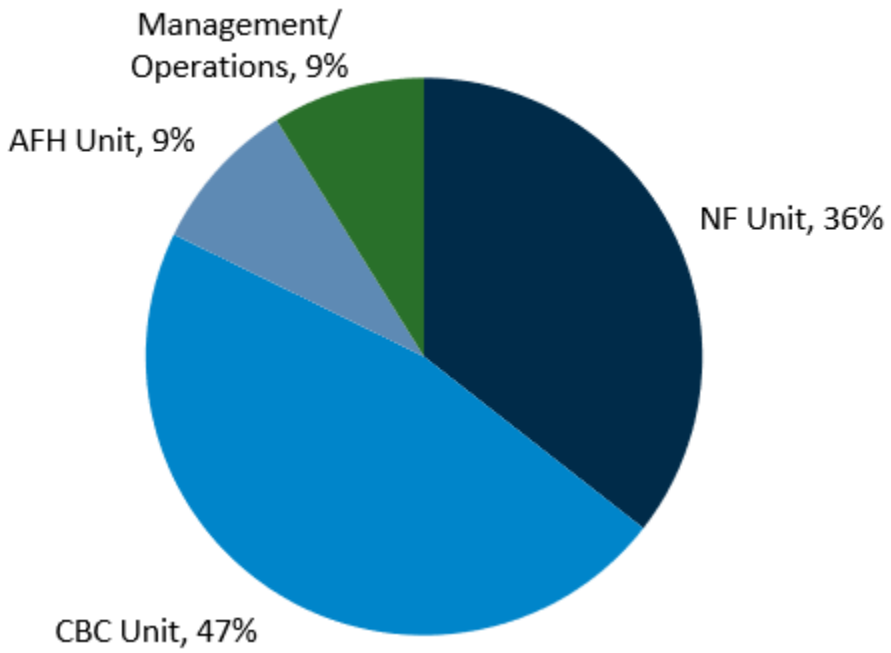
Interviews and Focus Groups

A&M completed informational interviews with a representative group of SOQ staff made up of members from all subunits within SOQ and across all ranks of employees. A&M also completed informational interviews with 8 external stakeholders, including representatives from provider agencies and advocacy partners. Figure 2. Share of SOQ staff interviewees & focus group participants by

SOQ shows the breakdown of the 45 SOQ staff that were interviewed (approximately 30% of the total number of SOQ staff in December 2024). The majority of participants provided feedback in an interview setting. A&M utilized a standardized interview protocol that asked questions about an interviewees' role and tenure within the unit, their perception of alignment with legislative mandates, their evaluation of strategy and SOQ performance, and their perspective on SOQ resource needs. Each interview lasted approximately one hour and the majority of the interviews were completed with two assessment team members present in an effort to reduce individual bias and strengthen the comprehensiveness of collected information.

A&M also collected information specifically related to the CBC unit through three focus groups. These focus groups were set up ensure adequate representation from the CBC team. Approximately 15 people participated in the focus groups. One person participated in both an individual interview and a focus group.

Figure 2. Share of SOQ staff interviewees & focus group participants by SOQ unit



To analyze the information collected, A&M pulled 5 main themes from the interviews and focus groups. These themes were categorized, sorted, and collapsed into final findings based on prevalence. Findings related to alignment

with legislative mandates were summarized in the Findings section of this report. Findings related to other areas, such as operational improvements or culture-related findings, were not included in this report, but will be included in future work products.

State Statute and Rule

A&M reviewed a set of 14 statutes that were likely to include information related to SOQ facility management, and based on relevancy chose to complete a detailed review of two statutes: ORS 441 & ORS 443. To collect information from these statutes, A&M summarized each relevant mandate and authority into an inventory that included categorization into type of legislative direction, applicable operational category, governed facility type, and a score of each item's level of ambiguity. A&M also chose to include a small number (<10) of legislative directions from ORS 101, ORS 476, and ORS 101 in this inventory. In total, 228 items were inventoried: 178 mandates and 56 authorities. The statutes that were reviewed were selected in collaboration with SOQ leadership.

In addition to these detailed statutory reviews, A&M completed a summary-level review of 26 rules from OAR Chapter 411. This review included documenting the following elements for each regulation: operational category, rule summary, regulated entity, summary of programmatic requirements for providers, summary of administrative requirements for providers, summary of Department implementation responsibilities, summary of potential areas of confusion, and, if applicable, a summary of the process requirements included in each rule. The rules that were reviewed were selected in collaboration with SOQ leadership.

Reviewing, categorizing, and cataloguing the state statutes and rules into these inventories enabled A&M to complete an analysis of clarity and consistency in legislative expectation by provider type and operational area. Additionally, the inventory of the statutory expectations enabled A&M to complete an analysis of the distribution of requirements across various areas. More detailed rule review was completed on a case-by-case basis.

SOQ Policies and Procedures

A&M requested and received operating policies and procedures from the SOQ unit. A&M reviewed 64 of these documents, categorizing them by operational area, and summarizing the key content/ intent of each document. In completing this review, A&M flagged items that were relevant to the scope of this project, but many of these procedures were not ultimately included in this analysis.

SOQ Training Materials

A&M focused training material review on two manuals from the CBC team that provide the most procedural detail about how the team should complete their work. Other training manuals were not provided to A&M. These include the *CAC Training and Resource Guide* and *the LCU Complaint Process Guide*. These items were consulted to corroborate information shared with the A&M team in interviews, and to compare against statute to identify any gaps.

NFSU surveyor training is heavily prescribed through federal government standards known as the Surveyor Minimum Qualifications Test (SMQT).[7] Due to the established framework for training staff according to that federal doctrine, A&M did not complete additional analysis of the NF unit's approach.

SOQ Job Descriptions

To effectively analyze current roles and structure within the SOQ organization, A&M summarized and catalogued 28 position descriptions for SOQ job roles. Across the CBC, AFH, NFSU, and Operations verticals, the primary purpose for each position description was documented. In addition to the primary purpose of each role, the major duties, typical decisions and direct impact of decisions, and qualifications were listed. If explicitly mentioned, it was noted that a role required a degree, degree equivalent, or any clinical expertise. Finally, an estimate was made of each role's regulatory expertise based solely on the job description. With this information summarized and compiled across roles and verticals, it was

[7] "State Operations Manual Chapter 4- Program Administration and Fiscal Management," Medicare State Operations Manual, Accessed December 2024, https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/som107c04pdf.pdf

possible to compare similar positions and overall organizational structure as they relate to expected behaviors and expertise.

V. Federal Policy Background

Long-Term Care facility-based services are funded and regulated by a combination of federal and state dollars and oversight. Adult Foster Homes and Community Based Care settings, including Assisted Living and Residential Care Facilities, are primarily state regulated through Oregon Administrative Rules; they are also subject to federal Home- and Community-Based Service (HCBS) standards for resident rights and freedoms.

Nursing facilities that receive Medicare/Medicaid payments are primarily federally regulated by the federal Centers for Medicare and Medicaid Services (CMS) and also receive oversight from the state in which they operate. The primary mission of CMS is to administer the Medicare and Medicaid programs to promote timely and economic delivery of services to beneficiaries, promote beneficiary awareness of eligible services, and promote efficiency and quality within the health delivery system. States enter agreements with the federal Department of Health and Human Services to certify nursing health care facilities to ensure compliance with federal regulations. They are licensed annually by SOQ staff who meet CMS required training standards. Certification of nursing homes is carried out through facility surveys, which fall into four main categories: certification of new facilities to ensure compliance with federal regulations; recertification of established facilities, or standard surveys, to ensure continued compliance; complaint investigations; and focused infection control surveys.

Complaint investigations explore licensing violations and abuse complaints that have been reported by residents, family members, or LTCO representatives. In nursing facilities, Immediate Jeopardy (IJ), as defined in 42 CFR 489.3, complaints are the most serious and refer to situations that have or may be likely to cause injury, harm or death. According to federal regulations, these complaints must be investigated within three business days of initial report.[8] Non-IJ High Risk complaints are complaints that may have caused or are likely to cause harm and where rapid response is indicated. These complaints must be investigated within

[8] This timeframe differs from Oregon statute, which requires surveyors on site within 2 hours following an IJ complaint.

18 days of report. Non-IJ Medium Risk are complaints that pose less risk to patients and must be investigated within 45 days, while Non-IJ Low Risk complaints are monitored for trends but do not require a standalone complaint survey.

In addition to CMS guidelines that regulate nursing facilities receiving federal funding, Home and Community Based Services (HCBS), established through Section 1915 of the Social Security Act, are Medicaid funded services designed to support individuals' ability to remain in their home or in community and prevent or delay their transition to institutional care. There are several HCBS options available to state Medicaid agencies, including:

- 1915(c) Home and Community Based Waivers to support the needs of individuals who prefer to get long-term care services in their home or community instead of a facility.
- 1915(i) State Plan Home and Community-Based Services to provide acute-care medical and long-term services in home and community-based settings.
- 1915(j) Self-Directed Personal Assistance Services Under State Plan to provide personal care and related services through the existing State Plan or 1915(c) waivers.
- 1915(k) Community First Choice which allows States to provide home and community based attendant services for Medicaid enrollees under their State Plan.

An array of Medicare and Medicaid program options exist to fund services in the settings that SOQ licenses. Each of these programs is operated with unique, program-specific requirements for quality management and oversight. They include the Aged and Physically Disabled Waiver, Oregon K Plan, and the Program for All-Inclusive Care for the Elderly.

In Oregon, the Aged and Physically Disabled Waiver (APD Waiver) is a 1915(c) waiver that assists nursing home residents in moving back home or to another community setting (assisted living or adult foster care). Assistance includes case management, housing search assistance, and payment of security deposit, utility

set up fees, or essential household items costs. The APD waiver previously supported HCBS such as home modification, meal delivery and Assistance with Daily Living (ADL), however, these services are now available through the K Plan.

The Oregon K Plan/Community First Choice Option (1915(k) State Plan Amendment) is designed for seniors and people with disabilities who require a level of care equivalent to nursing home services. K Plan services can be provided in a beneficiary's own home, the home of loved one, and adult day center, assisted living, memory care, or an adult foster home. The service breadth is wide and includes attendant care, chore services, transportation, medication management, memory care support, and nurse delegation and care coordination, among others.

The Program for All-inclusive Care for the Elderly (PACE) is a Medicare program and Medicaid service option available in Oregon. Participants can receive PACE in their own home or alternate care settings. The PACE program provides all health and long-term care services covered by Medicare and Medicaid. Most services can be provided at a single location in a coordinated system. An interdisciplinary team (IDT) works with individuals and families to develop a person-centered care plan that is delivered through the PACE organization. Individuals may live in their own home, an adult foster home, an assisted living facility, or a residential care facility and participate in PACE as long as they reside in a PACE service area and agree to receive health and care services through the PACE organization only.

Sector Promising Practices

Federal guidance issued in 2021 outlines national priorities for facility management in nursing facility settings[9]. A&M recommends that Oregon use these nursing facilities principles as a basis for provider management in other long-term care settings. Federal guidance identifies three areas of focus:

- Staffing;

[9] FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes, " The White House, Accessed December 2024, https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/

- Accountability for Poor Performance; and
- Transparent Data.

Each of these reform areas is meant to improve the safety and quality of care provided in residential settings for elderly and/or disabled people. Figure 3. provides an overview of federally promoted initiatives within each of these areas and relevant Oregon activities and opportunities.

Staffing reforms include recommendations to pursue a minimum staffing requirement for facility-based care, interventions to promote single occupancy rooms, and value-based payments. Of these interventions, establishing and monitoring staffing thresholds is included in SOQ's authority. While nursing facilities are subject to a minimum staffing requirement, CBC-managed facilities are held to an acuity-based staffing model that does not require a specific minimum requirement be met.

Accountability reforms include recommendations to increase funding for inspection activities, increase oversight of low performing providers, expand and update financial penalties for non-compliance, broaden sanctions/ licensing conditions for chain owners of substandard facilities, and increase technical assistance to facilities. Nursing facilities are held accountable to both state and federal civil penalties for poor performance. CBC-managed facilities are held accountable to state statute established civil penalties. These civil penalties have state statute determined amounts based on severity of the facility infraction, along with mandated ceilings for total amounts charged. These amounts have not been updated since 2017, which suggests that the efficacy of civil penalties as a deterrent and/or as incentive to come into compliance is not as potent as originally intended by the legislature in 2017.

Data transparency reforms include recommendations/ stated intent to begin tracking owners and operators across states, increase efforts to expand public reporting about facility finances, and enhance online platforms such as Nursing Home Compare which is used by residents and families to evaluate settings.

Figure 3. Summary of federally determined promising practices and Oregon opportunities

Federal Leadership	Oregon Progress & Opportunities
Staffing	
• Establish minimum staffing requirements • Value-Based Payments • Single Occupancy Rooms	• SOQ has implemented a minimum staffing requirement of 2 nursing staff at all times in nursing facilities. (OAR 411-086-0100) • SOQ does not have a clear minimum requirement for staff in facilities managed by the CBC unit. Staffing levels for this facility type (assisted living) are based on resident acuity. (OAR 411-054-0700) • Values-based payment structures and the promotion of single occupancy rooms are outside of the scope of SOQ's licensing role.
Accountability	
• Increase funding for inspection activities • Increase oversight of poor performing facilities • Expand financial penalties • Broaden sanctions for chain owners • Increase technical assistance	• National trends indicate that funding for nursing facility inspections have remained flat for much of the past decade, even while complaints (workload) have increased. Financial analysis of workload, funding, and staffing is needed to better understand if SOQ is adequately funded and resourced. • SOQ has already implemented an enhanced monitoring program for poor performing community-based care facilities. Better data reporting, such as a consistent record of provider licensing deficiencies and remediation success, to establish which facilities should enter into this program, would make it more effective. • SOQ has already implemented a civil penalty structure for nursing facilities, facilities managed by CBC, and the AFH Unit. Evaluation of these civil penalty amounts against facility finances should be conducted to determine appropriateness and effectiveness. • Explore accountability structures focused on owners of multiple facilities with poor performance, such as levying penalties or applying licensing conditions across all sites operated by an individual owner. • Evaluate technical assistance opportunities for providers, particularly for the most common licensing violations.
Transparency	
• Report facility ownership data across states • Expand reporting of facility finances • Improve Nursing Home Compare	• SOQ currently maintains an online platform that provides information about facility status, current corrective issues, and recent survey/ inspection visits. This platform could be improved by adding additional search or export features.

VI. Findings

SOQ Mandates & Authorities

Through completing statutory review, A&M has identified the following findings related to the prevalence, consistency, and clarity of relevant legislative mandates and authorities.

The distribution of state legislative requirements is uneven across different provider types and operational area managed by the SOQ unit. A&M catalogued approximately 230 individual mandates and authorities from Oregon Revised Statutes. Figure 4. Heatmap of state statutory mandates and authorities by facility type and operational area illustrates the breakdown of legislative expectations. This figure uses color saturation to indicate the prevalence of requirement types within specific intersections of facility type and operational area. Each percentage represents that share of the total number of requirements and authorities that apply to a specific facility type and operational area. (Ex. Around 2% of the requirements that A&M catalogued from ORS 441 and ORS 443 apply to how SOQ should manage Initial Licensing Application reviews for Nursing Facilities.) The majority of statutory requirements pertain to community-based care facilities. In contrast, adult foster home governance is substantially less prescribed. Most requirements are specific to a single facility type, though a small portion applies to multiple facility types. The variation in requirement prevalence across these areas is significant because the level of legislative oversight in a given policy area influences the policy-making activity of and staff expertise within the implementing agency.

Figure 4. Heatmap of state statutory mandates and authorities by facility type and operational area

	Initial Licensing Application	Ongoing Licensing Reviews	Complaints & Investigation	Corrective Action Management	Day-to-Day Operations	Other	Total
Nursing Facilities	2%	5%	18%	0%	8%	3%	37%
Community Based Care Facilities	6%	4%	3%	3%	4%	6%	25%
Adult Foster Homes	3%	4%	3%	0%	5%	1%	16%
Nursing Facilities & Community Based Care	0%	0%	3%	8%	0%	0%	11%
Adult Foster Homes and Community Based Care	0%	1%	7%	0%	0%	1%	9%
All	0%	0%	0%	0%	1%	1%	2%
Total	10%	14%	34%	12%	19%	12%	100%

There is a high level of consistency in the guiding priorities set by the legislature across different facility types. However, there is only a low-to-moderate level of consistency in operational mandates and authorities across these facility types. ORS 441.726 (Nursing facilities and Community based care facilities), ORS 443.446 (Community based care facilities), and ORS 443.725 (Adult foster homes) establish goals for the Department's licensing and compliance systems.

The guiding priorities are for ODHS to:

- prioritize the health, welfare, safety, and rights of residents. (Nursing Facilities and Community Based Care Facilities)
- safeguard residents' health, safety, and uninterrupted receipt of services. (Adult Foster Homes)
- consider the severity and scope of a facility's noncompliance when requiring corrective action. (Community Based Care Facilities)
- as appropriate, use a progressive enforcement process to encourage and compel provider compliance. (Nursing Facilities and Community Based Care Facilities)

These guiding priorities are largely harmonious with one another, clearly establishing that the Department must protect resident wellbeing without resorting to overly punitive measures. Though expectations vary slightly across facility types, the intent remains effectively the same. However, embedded in the statutory intent is a tension that SOQ must manage between providing support to the provider network, and providing accountability, so that residents are adequately protected. This tension leads to operational challenges.

Expectations begin to diverge when more detailed operational mandates and authorities are analyzed. Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type includes a selection of key expectations. While these expectations do not conflict with one another, they do not often align perfectly across facility type. They also do not always align perfectly with federal expectations. This means that when SOQ is facing questions about things such as investigation response times or facility closures, the unit must navigate differing legislative expectations based on facility type and may appear to act inconsistently to outside parties. For example, NF must meet more stringent investigation response times than CBC. An additional effect of this structure is that staff who occupy shared services roles (e.g. policy making, operations, safety coordination) must be able to provide direction across teams who are required to respond to the the same type of situations in very different ways.

Additionally, some facility types have multiple, overlapping statutory authorities that govern a type of operational activity. For example, the Department is authorized to appoint an interim facility manager if resident health and safety is threatened AND the licensee agrees to the appointment (ORS 441.333). The Department has authority to immediately suspend a license of any residential care facility in cases of imminent danger to the health or safety of residents, pending a fair hearing. In cases of immediate suspension, the Department may also appoint an interim management company (ORS 441.421). These overlapping authorities and the granting of authority without creating mandated actions make it challenging to determine the legislative intent regarding when license revocation should occur and create an operational gray area where decisions about interim management and revocation are likely to be made on a case-by-case basis with provider input, rather than in a systematic, Department-led approach that sets clear expectations for the SOQ team, providers, and the public.

Another example of potentially unclear statutory expectations relates to investigation timelines for community-based care facilities and adult foster homes. These requirements hinge upon the interpretation of three words/phrases that relate to the timeliness and initiation of investigations. These words/phrases are: “without undue delay,” “immediately,” and “promptly.” Generally, statutory requirements indicate that legislative intent is that the Department triage investigations based on the potential impact to resident well-being. However, without further detail to support these vague and similar terms established in either statute or department regulation, the Department potentially lacks the structure needed to complete investigations with the haste needed to provide a meaningful intervention for people and families. Implementing regulations OAR 411-052 and OAR 411-054 do not provide more specific timelines than the ones outlined in statute.

Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type

Key statutory mandates and authorities		
Nursing facilities	**Community based care facilities**	**Adult foster homes**
Licensure		
1. Required to complete an on-site inspection as a part of initial licensing application review 2. Required to complete a general inspection of each long-term care facility each calendar year 3. Required to complete inspections without advance notice **ORS 441.025(2)(a), ORS 441.087**	1. Required to license these facilities 2. Required to conduct an on-site inspection as part of initial licensing application review 3. Required to periodically visit and inspect each facility to assess ongoing compliance **ORS 443.410, ORS 443.415, ORS 443.416, ORS 443.417**	1. Required to license Adult Foster Home providers, and to adopt rules about licensing standards that safeguard residents' health, safety, and uninterrupted receipt of services 2. Authorized to enter and inspect all licensed homes, and in certain circumstances, unlicensed homes that are operating despite being unlicensed 3. Authorized to adopt building code standards that are more stringent than local requirements if there is a significant health or safety threat 4. Required to ensure that the provider can evacuate within 3 minutes (or within the relevant timeline if a sprinkler system is in place) **ORS 443.725, ORS 443.755, ORS 443.760**
Kitchen Inspections		
1. Required to complete as a part of initial licensing application review and when a reapplication application is received **ORS 441.025**	1. Required to complete as part of initial licensing application review 2. Required to annually inspect facility kitchens 3. Authorized to refuse a renewal application if a facility fails a kitchen inspection **ORS 443.415, ORS 443.417, ORS 443.425(2)**	No applicable statutory mandates or authorities
Complaint Investigations		
1. Required to commence an abuse investigation within 2 hours if the complaint alleges that resident has	1. Required to complete a certain set of investigation activities (interview witnesses, physical	1. Required to begin a complaint investigation immediately when the

Key statutory mandates and authorities		
Nursing facilities	**Community based care facilities**	**Adult foster homes**
died, been hospitalized, or is in imminent danger 2. Required to commence an abuse investigation by the end of the next working day if the complaint alleges that abuse could occur or that health and safety could be in imminent danger 3. Required to meet several process requirements for abuse investigations including progress report timelines, specific investigation requirements, and summary report elements. 4. Required to complete non-abuse related investigations within 90 days. 5. Required to meet several process requirements for non-abuse investigations including specific investigation requirements, and summary report elements. 5. Required to complete a letter of determination with substantiation findings within 120 days of the investigation commencement. 6. Required to complete a certain set of investigation activities (interview witnesses, physical inspection, review documents and records, personal observation, findings statements) **ORS 441.650, ORS 441.676, ORS 441.677, ORS 441.695**	inspection, review documents and records, personal observation, findings statements) 2. Required to assess staffing levels when investigating complaints of harm (not abuse) or complaints related to staffing levels 3. Required to begin investigations related to harm (not abuse) or unqualified staff without undue delay 4. Required to include specific elements in an investigation report when investigation harm (not abuse) and staffing (personal observations, review of documents and records, summary of witness statements, findings and fact basis) **ORS 441.695, ORS 443.441**	Department receives a complaint that a resident has been injured, abused, neglected, or that the resident has died or been hospitalized 2. Required to begin a complaint investigation promptly when a complaint alleges the existence of a circumstance that could result in injury, abuse, or neglect 3. Requires investigations to be complete within 60 days. 4. Requires appropriate corrective action to be taken no more than 60 days following the completion of an investigation. **ORS 443.767**
Provider Staffing Levels		
1. Required to adopt rules specifying the maximum number of patients per nursing assistant per shift 2. Authorized to grant a variance in staff requirements based on patient needs and nursing practices **ORS 441.073**	1. Must develop or obtain, maintain and use, in collaboration with residential care facilities an objective tool 2. May, but is not required to, use the tool to evaluate facility staffing levels 3. Required to make the tool available to facilities 4. Required to use the tool when imposing a staffing requirement on a facility when the facility disagrees **ORS 443.432**	1. Authorized to allow a person who does not meet staffing requirements (training, etc.) to serve as a resident manager for up to 60 days, if the Department determines that an urgent and unexpected staffing need exists 2. The provider themselves or a residential manager hired by the provider must live in the home A provider or substitute caregiver must be on duty 24 hours a day **ORS 443.738, ORS 443.725**

Key statutory mandates and authorities		
Nursing facilities	**Community based care facilities**	**Adult foster homes**
Licensing Revocation, Suspension, or Refusal to Renew		
1. Authorized when there has been substantial failure to comply with licensing statute, rule, or Department order 2. Required to deny, suspend or revoke a license if there has been a substantial failure to comply with requirements related to safety from fire. **ORS 441.030**	1. Refusal to renew is required when a facility is not in "substantial compliance" with applicable laws and rules 2. Authorized to revoke or suspend when a facility is not operated in accordance with licensing statutes and rules 3. Authorized to immediately suspend a license when an imminent danger to resident health exists, pending a fair hearing 4. Authorized to close a facility after revocation notice has been given and residents have been placed in a new home **ORS 443.421, ORS 443.425, ORS 443.991**	1. Authorized when there is 1) a health and safety issue, 2) evidence of abuse, neglect, or exploitation, or 3) other circumstances of non-compliance 2. Authorized to enjoin operation of a home after revocation notice has been given and residents have been placed in a new home **ORS 443.745, ORS 443.991**
Condition Issuance		
1. Required in immediate jeopardy situations (with some direction given about when to restrict admissions) 2. Authorized in other situations of non-compliance **ORS 441.736**	1. Required in immediate jeopardy situations (with some direction given about when to restrict admissions) 2. Authorized in other situations of non-compliance 3. Authorized when there is a threat to health or safety, there is evidence of abuse, neglect or exploitation, or when the facility is out of compliance with statute/rule 4. Required in staffing shortage situations **ORS 441.736, ORS 443.419, ORS 443.889**	3. Authorized when there is 1) a health and safety issue, 2) evidence of abuse, neglect, or exploitation, or 3) other circumstances of non-compliance **ORS 443.745**
Interim Management		
1. Authorized to petition a circuit court for the appointment of a trustee to administer the facility when resident health and welfare is in immediate jeopardy 2. Authorized to appoint, with the consent of the licensee, a temporary manager if the Department determines the residents to be in immediate jeopardy	1. Authorized to petition a circuit court for the appointment of a trustee to administer the facility when resident health and welfare is in immediate jeopardy 2. Authorized to appoint, with the consent of the licensee, a temporary manager if the Department determines the residents to be in immediate jeopardy	No applicable statutory mandates or authorities

Key statutory mandates and authorities		
Nursing facilities	**Community based care facilities**	**Adult foster homes**
ORS 441.277-286, ORS 441.333	3. Authorized to appoint a management company to manage the facility after an immediate license suspension (based on imminent danger to health or safety) **ORS 441.277-286, ORS 441.333, ORS 443.421**	
Enhanced Oversight and Supervision Program		
No applicable statutory mandates or authorities	1. Required to administer a program for residential care facilities that demonstrate consistent poor performance 2. Authorized to compete certain remediation activities like increased surveys or licensing conditions on facilities in the program 3. Required to graduate facilities from the program within certain time frames based on their performance 4. Requires public posting of the facilities in the program on the web **ORS 443.436**	No applicable statutory mandates or authorities

State & Federal Requirement Tensions | Nursing Facilities

One challenge for SOQ is the lack of alignment that exists between state expectations and federal expectations governing the oversight of nursing facilities. There are three notable areas of misalignment.

1. **Abuse Definitions** – The state has a broader definition of abuse than the federal government, including physical injury that appears to be at variance with the explanation given for the injury (ORS 124), and not including criteria related to the result of the action, as included in the federal definition (42 CFR Part 483).
2. **Complaint Response Timelines**- The state requires a two-hour response for immediate jeopardy or that the resident has recently died, been hospitalized or been treated in an emergency room, and an approximately 32-hour response time for complaints of imminent danger.[10] The federal

[10] "Prior to the end of the next working day" ORS 441.650

government requires a response time of two days for immediate jeopardy and does not define a situation type of "imminent danger."

3. **Work Prioritization** – CMS issues annual guidance about how to prioritize surveys and investigations in long-term care settings.[11] This guidance establishes a 4-tier framework, where each tier of work must be completed before the next tier of work is addressed. The first tier includes immediate jeopardy complaint investigations and initial licensing surveys.

These areas of misalignment, coupled with the corresponding federal expectations about how investigations and surveys should begin and be conducted, make it difficult (potentially impossible) for the SOQ team to meet both sets of expectations simultaneously.

Figure 6. Findings summary | SOQ contains a summary of the findings described in this section.

Figure 6. Findings summary | SOQ mandates & authorities

ID	Finding	Evidence	Implication
1	The distribution of state legislative requirements is uneven across different provider types and operational area managed by the SOQ unit.	• Statutory Review and Analysis • Figure 4. Heatmap of state statutory mandates and authorities by facility type and operational area	• SOQ staff will need varying levels of policy and operational analysis skills depending on what facility type they manage.
2	The Department is given consistent guidance about what to prioritize in facility management (resident wellbeing, not overly punitive approach).	• Statutory analysis of ORS 441 & ORS 443 • Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type	• While the high-level approach is clear, the implementation strategy to achieve this goal is not. SOQ staff and management are put in the position of navigating the degree of punitive that will be most effective/ well-

[11] "Fiscal Year (FY) 2025 Mission & Priorities Document (MPD) – Action," Center for Clinical Standards and Quality, January 13, 2025, https://www.cms.gov/files/document/admin-info-25-05-all.pdf.

ID	Finding	Evidence	Implication
			received at any given time.
3	The Department must respond to varying operational expectations based on facility types.	• Statutory Review and Analysis • Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type	• SOQ staff will need varying levels of policy and operational analysis skills depending on what facility type they manage.
4	Some unclear statutory expectations are not further detailed in Department rule.	• Statutory analysis of ORS 443.441 & ORS 443.767 • Administrative rule analysis of OAR 411-054 7 OAR 411-052	• SOQ has not established clear consumer protections regarding response times for CBC and AFH investigations.
5	The Department must navigate overlapping authorities and mandates within certain operational areas.	• Statutory analysis of ORS 441.333 & ORS 443.421 • Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type	• SOQ has not established a systematic, Department-led approach to licensing revocation and interim facility management.
5.5	The Department must navigate federal and state requirements that are not always in alignment and are challenging to comply with simultaneously.	• Statutory analysis of ORS 441 • Review of CMS Mission and Priorities Document 2025 • Review of internal SOQ policy document describing prioritization approach (Dec 2024)	• The operational structure of NFSU is based on federal requirements, which can create conflict with state expectations (e.g., federal prioritization of surveys and Type A complaints v. state complaint categories that do not align with federal definitions).

SOQ 2024 Operational Alignment as Described by Staff & Related Issues

This section includes discussion of SOQ self-reported observations about the unit's degree of operational alignment with legislative mandates. Interviewees indicated that alignment between practice and legislative mandates within SOQ is a challenge, particularly in the CBC unit, and noted that a lack of a shared understanding of organizational vision and strategy could contribute to poor alignment. Interviewees also reported that this lack of alignment manifests as inconsistencies in enforcement actions.

Figure 7. Self-reported alignment of practice with policy by facility type

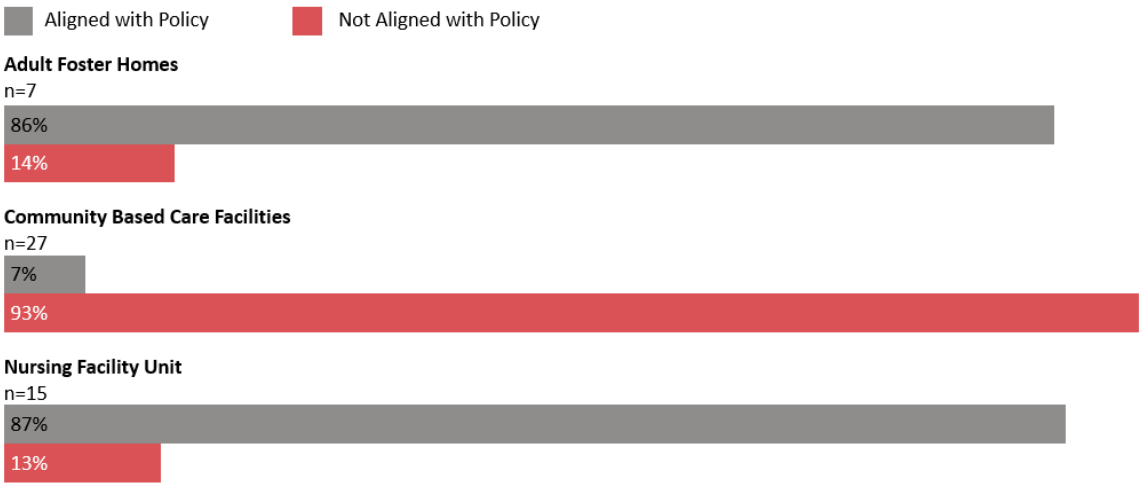


Figure 7. Self-reported alignment of practice with policy by facility type shows a clear difference in perceived alignment across the three units. Interviewees reporting on AFH alignment generally expressed confidence in the correspondence between SOQ operations and legislative mandates. While interviewees addressing NF were also confident in its alignment with legislative mandates, a distinction was made between federal and state-level mandates. Some interviewees suggested federal mandates are more important than state mandates, even when state-level mandates were more stringent. This suggests misalignment in NF with state mandates. Regarding CBC, interviewees indicated it was not in alignment with regulatory expectations to the extent those expectations were understood. Those few respondents who felt CBC successfully aligned noted that the survey teams in particular were most aligned. Looking across interviewee responses from AFH, NF, and CBC indicate that the

understanding of legislative mandates and support to develop that understanding vary significantly within SOQ by unit.

One potential contributing factor to the reported lack of alignment in the CBC unit is lack of consistent direction from SOQ leadership over time (including lack of consistency through leadership changes) about *how* to achieve facility compliance. Multiple tools are available to SOQ to encourage and compel compliance including issuing civil penalties, offering technical assistance to providers, and/ or imposing licensing conditions such as restrictions on new admissions. Many SOQ staff reported confusion about or mistrust of the implementation of some of these levers as a method to achieve compliance. Additionally, staff noted a connection between executive leadership and policy interpretation at any given time. Simply put, staff reported that policy changes when new leadership is established for SOQ, and that the individual style, interpretation, or preference of an SOQ leader is what drives staff's work. This sentiment was also expressed by outside partners such as providers and advocates who have observed SOQ throughout multiple administrations.

The reported variance in enforcement styles was typically described as an oscillation between prioritizing encouraging providers to achieve compliance through supportive means (technical assistance) versus encouraging providers to achieve compliance through more punitive means (fines & licensing restrictions). When expectations for how to make decisions about facility oversight are not clear and consistent, staff are left to utilize personal discretion. Organizationally, in some units within SOQ, staff are divided into teams based on their expertise. For example, within CBC, one team (the corrective action coordinators) work on determining and issuing corrective actions for providers, and another team (the operations and policy analysts) work on interpreting / developing policy and providing technical assistance / support to providers. In practice, interviewees report that both teams collaborate to make decisions about facility compliance strategies. Mingling staff with two different types of expertise and strategic goals likely muddles the application of enforcement strategies within CBC, particularly when there is a lack of uniform guidance / policy on enforcement strategies. One interviewee shared that the perception is that the operations and policy analysts

sometimes tend to favor less stringent licensing actions, even in situations when licensing violations have been substantiated.

To mitigate swings in interpretation that may occur when personnel changes, or to enforce consistency across staff with different approaches, SOQ could implement standard policies and procedures. However, interviewees did not consistently praise the quantity or quality of existing standard operating procedures. While some strengths were noted, particularly the survey guidance offered to both CBC and NF, interviewees reported a lack of clear guidance within the CBC unit about how to make facility management decisions such as investigation protocols, condition issuance, and the granting of exemptions. One interviewee summarized this frustration as a feeling of "disconnect", noting they "hadn't reviewed all the policies since being hired". Well-intentioned members of SOQ seem frequently unsure if the decisions they make align with current policies. Interviewees also outlined a process to update policies and procedures that can sometimes take multiple years. As the updates "need to be reviewed by many people", staff noted the consequence of "losing sight of the bigger picture" as updates worked through the lengthy process.

Another potential mitigating factor for lack of alignment is the ability-level of individual leaders and the tenure/experience level of staff. Maintaining a staff of individuals that are passionate about their mission contributes to organization effectiveness and has tangible impacts on organizational costs such as turnover. Many interviewees shared positive feedback about their peers and direct supervisors. Staff were described as 'passionate, talented' people, who are 'committed to doing a good job'. Figure 8. Self-reported average tenure by SOQ unit shows the ample experience that staff members have within the SOQ organization, experience they are able to leverage and apply to the work they do. Potential pain points emerge when middle management, with comparable less experience, is given management authority over groups with longer tenure. The middle management layer within SOQ reported under 5 years of SOQ experience, which is lower than the experience levels reported by staff. Some staff did report a sense that their direct supervisors do not have the specialized expertise needed to oversee their work well. Specifically, one staff member noted that due to the

volume of leadership changes that have occurred within SOQ, that unless a new manager demonstrates a clear understanding of the work to their staff, or "rolls up their sleeves" by engaging in operational details, the staff will not respect them or their directives.

Figure 8. Self-reported average tenure by SOQ unit

NF	AFH	CBC
13 years	5 years	8 years

To best leverage staff experience and adjust for friction associated with the comparatively less experienced middle-management, SOQ should rely on strong communication practices, established expectations for chain-of-command, and intentional alignment of messaging from Executive Leadership down to line staff.

A common challenge reported by SOQ staff that makes achieving compliance difficult is the number of staff. The majority of interviewees noted that staffing levels did not feel sufficient to complete the workload assigned to them. Multiple CBC staff compared the number of staff that the unit currently has to the number of facilities that the unit manages and pointed out a substantial, unfavorable differential between CBC staffing levels compared to either NFSU or APS. One staff said bluntly that they believe SOQ leadership understands staffing levels are not adequate, but that their expectations remain "unrealistic." Though CBC staff were the most detailed in describing their staffing challenges, the concerns were shared by SOQ staff in other units. Interviewees noted long recruitment processes, complex job requirements, low pay, and insufficient legislative allocations as contributors to current staffing levels.

To better understand SOQ staffing levels, A&M compared NF and CBC staffing data to a report published in 2023 by the US Senate Special Committee on Aging. This report shows staffing levels for nursing facility survey units across the country. The data show that the SOQ nursing facility unit is better staffed than peers across the country. However, CBC is staffed at a rate below the national average for nursing facilities. The federal report also points to a macro trend of underfunding and understaffing long term care facility oversight units across the country, meaning

that the national average may not be a sufficient metric against which to measure the perceived appropriateness of staffing levels.

Figure 9. Facility Bed to Surveyor Ratios

FY 2022 National Average[12]	NF Unit Ratio	CBC Unit Ratio
1:436 Beds	1:210 Beds	1:515 Beds

Expected impacts of lack of alignment and vacillating interpretations were observed by external partners. External partners noted that the way requirements were applied to them sometimes depends on which SOQ staff member is interacting with them. One person shared that they do not feel as though the unit is consistently effective, that there are inconsistencies, and that the same facility can sometimes receive either very positive or very negative feedback, depending on which surveyor they are interacting with.

Figure 10. Findings summary | SOQ operations contains a summary of the findings described in this section.

Figure 10. Findings summary | SOQ operations

ID	Finding	Evidence	Implication
6	SOQ staff self-report a low level of alignment between legislative mandates and CBC operations.	• Interview data as summarized in Figure 7.	• CBC interactions with facilities are likely to be inconsistent. • Key expectations established by the legislature may not be met.
7	SOQ staff self-report a high level of alignment between legislative mandates and AFH operations.	• Interview data as summarized in Figure 7.	• AFH interactions with facilities are likely to be consistent.
8	SOQ staff self-report a high level of alignment between legislative mandates and NF operations. However, they note a lower degree of alignment between operations and state	• Interview data as summarized in Figure 7.	• Nursing facility federal expectations are likely to be met. • Nursing facility state expectations are less likely to be met.

[12] "Uninspected and Neglected", U.S. Senate Special Committee on Aging, Accessed December 2024, https://www.aging.senate.gov/imo/media/doc/UNINSPECTED%20&%20NEGLECTED%20-%20FINAL%20REPORT.pdf

ID	Finding	Evidence	Implication
	expectations, compared to federal expectations.		
9	Staff report that policy interpretations tend to change each time new SOQ leadership is established, potentially compromising operational consistency and the staying power of various reforms.	• Interview data	• Strong change management practices are needed, otherwise new initiatives will not be implemented to fidelity. • Implementing a new change via a state regulation or statutory change are likely to have more staying power across administrations.
10	SOQ staff is more experienced than SOQ middle management, which could cause conflicts and change management related friction.	• Self-reported tenure as documented in interview notes	• Tension is likely to exist between middle managers and their staff. • Additional support may be needed to help new managers come up to speed. • Strong communication practices are needed.

Gap Identification & Alignment Analysis

Summary of Alignment

A&M assessed SOQ alignment with state statute in three primary areas which were chosen due to their impact on resident safety. These three areas are 1) Licensing and Renewal Surveys, 2) Licensing Corrective Actions, and 3) Licensing Investigations. Within these three areas, A&M identified compliance areas related to timeliness and decision making. Specifically, A&M has identified the following areas as compliance/alignment challenges.

Compliance Challenges:

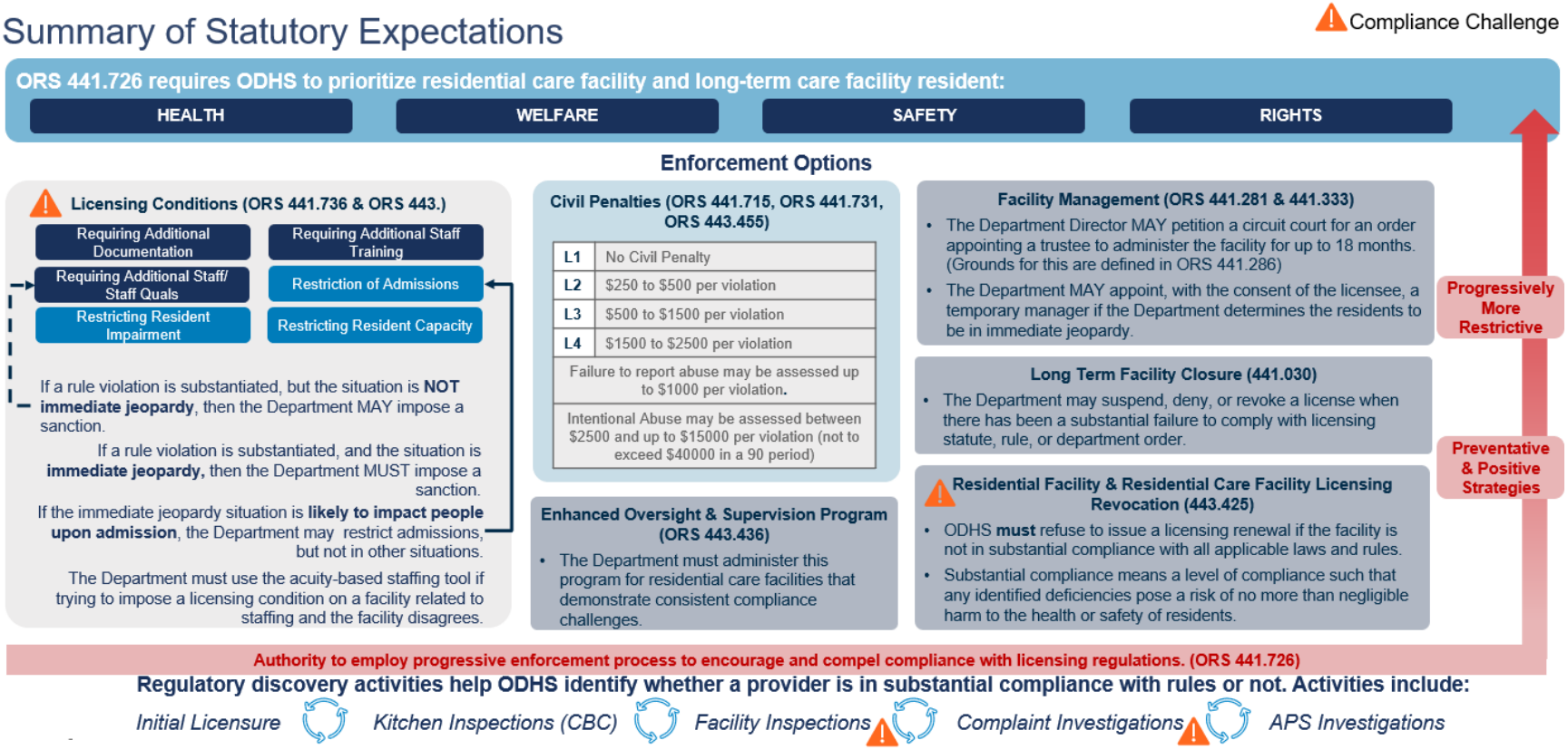
1. **CBC Licensing Survey Timeliness** – A&M found that the CBC unit is not completing surveys in accordance with the timelines established in state

law. (Contradicting statute, training materials indicate that licenses are issued to facilities that are not in substantial compliance.)

2. **CBC Licensing Renewals** – A&M found that CBC licensing renewals are being issued contrary to expectations outlined in state law. (Contradicting statute, only 8% of active facilities received a renewal survey visit within 2 years of their last visit.)
3. **CBC Condition Issuance** – A&M found that licensing conditions are not being issued in accordance with expectations established in state law. (Misaligned with statute, CBC uses letters of agreement to establish remediation expectations that are effectively licensing conditions.)
4. **AFH Facility Management** – A&M found that AFH facility management activities are not completed in accordance with expectations established in state law. (Interviewees indicate the surveys may not be completely impartial.)
5. **NF Investigation Timeliness** – A&M found that NF abuse investigations are not commenced in accordance with the timelines established in state law. (The investigation backlog indicates that a substantial portion of complaint investigations are 6 months or older.)
6. **CBC Investigation Timeliness** – A&M found that CBC complaint investigations are not commenced in accordance with the timelines established in state law. (CBC currently carries a backlog of over 4000 complaints, and in December closed under 200 cases, resulting in more cases being added to the backlog.)

Figure 11. Summary of statutory expectations with compliance challenges identified (CBC & NF) provides a visual summary of the statutory framework for the facilities that CBC and NF manage. This graphic shows the guiding principles established by the legislature, the discovery activities that SOQ undertakes to learn about facility compliance, and the enforcement tools available to SOQ to encourage facilities to comply with the standards that have been set to protect residents. As shown on the graphic, SOQ faces compliance challenges both in completing their discovery activities and in carrying out their enforcement practices.

Figure 11. Summary of statutory expectations with compliance challenges identified (CBC & NF)



Licensing Survey Timeliness

Interviewees from NFSU and AFH self-report alignment with licensing survey expectations, while CBC reports misalignment. Figure 12. Survey Timeliness by SOQ Unit shows a summary of the state legislative expectation by facility type as compared to self-reported compliance and data from 2024 and actual rates of compliance. The share of compliant surveys is currently depressed, in-part, due to planned delays in completing initial surveys during the Covid-19 pandemic. Survey activities were delayed and a backlog developed. The SOQ team has been devoting resources to working through the backlog and returning to completing surveys in a normal way, post the public-health crisis.

Figure 12. Survey Timeliness by SOQ Unit

SOQ Unit	State Requirement	Self-Reported Compliance	Share of Compliant Surveys (2024)
NFSU	1 Year	Moderate	*4.3%*[13]
AFH	1 Year	High	*78%*
CBC	2 Years	Low	*8%*

Initial licensing surveys and regular revisits at licensing renewal are a key component of facility management and consumer protection. They are the primary preventative tool available to SOQ and are used to assess compliance before any allegations of noncompliance are made. If SOQ is unable to perform this prospective intervention, for any reason, then resident safety and facility quality are potentially compromised.

Licensing Renewals for Residential Facilities or Residential Care Facilities (CBC)

Review of desk level procedures suggest that the CBC unit may not be completing licensing renewal activities as outlined in statute. ORS 443.425 establishes the expectation that a licensing renewal not be issued for a facility unless that facility is found to be substantially compliant with applicable laws and rules. However, a guide for the CBC unit's Corrective Action Coordinators (CAC) includes instruction

[13] CMS has less stringent requirements for the frequency of survey completion. States are required to maintain an average length of time between surveys of 12.9 months.

to send Letters of Agreement (LOAs) to facilities along with emails that state the LOA is "an effort to assist the facility to come back into substantial compliance…" An LOA is an informal action taken by CBC as an effort to resolve a compliance issue before progressing to a more stringent licensing condition.

Substantial compliance is not defined in ORS 443.425, but a related statute includes the following definition, "'Substantial compliance' means a level of compliance with state law and with rules of the Department of Human Services such that any identified deficiencies pose a risk of no more than negligible harm to the health or safety of residents." A&M did not receive feedback from SOQ staff that licensing renewals were issued to CBC facilities that posed substantial health and safety risks to residents. However, the use of the phrase "substantial compliance" in the sample LOA template indicates that CBC may lack clear internal procedures for determining substantial compliance and may also lack a clear understanding of the legal importance and implications of that phrase.

Imposing Licensing Conditions on a Residential Facility, or a Residential Care Facility (CBC)

The CBC unit's licensing condition practices demonstrate inconsistencies with state statutory expectations. ORS 441 and ORS 443 establish guiding principles for when the Department has the authority or obligation to impose a licensing condition on a facility. The statutes also provide a non-exhaustive list of licensing conditions for the Department to reference as examples. The implementing regulations for community-based care facilities reiterate these statutory expectations with limited regulatory content that is more detailed or stringent than the requirements included in state statute. In practice, SOQ has not consistently issued licensing conditions as outlined in statute as evidenced by perceived changes in statutory interpretations, internal inconsistencies in making high-impact determinations, and the use of non-regulated activities as an alternative to issuing a condition. This lack of alignment weakens SOQ's ability to perform consistent facility oversight statewide.

Informational interviews and procedure review regarding changes in statutory interpretation suggest that the CBC unit has not, until recently, imposed

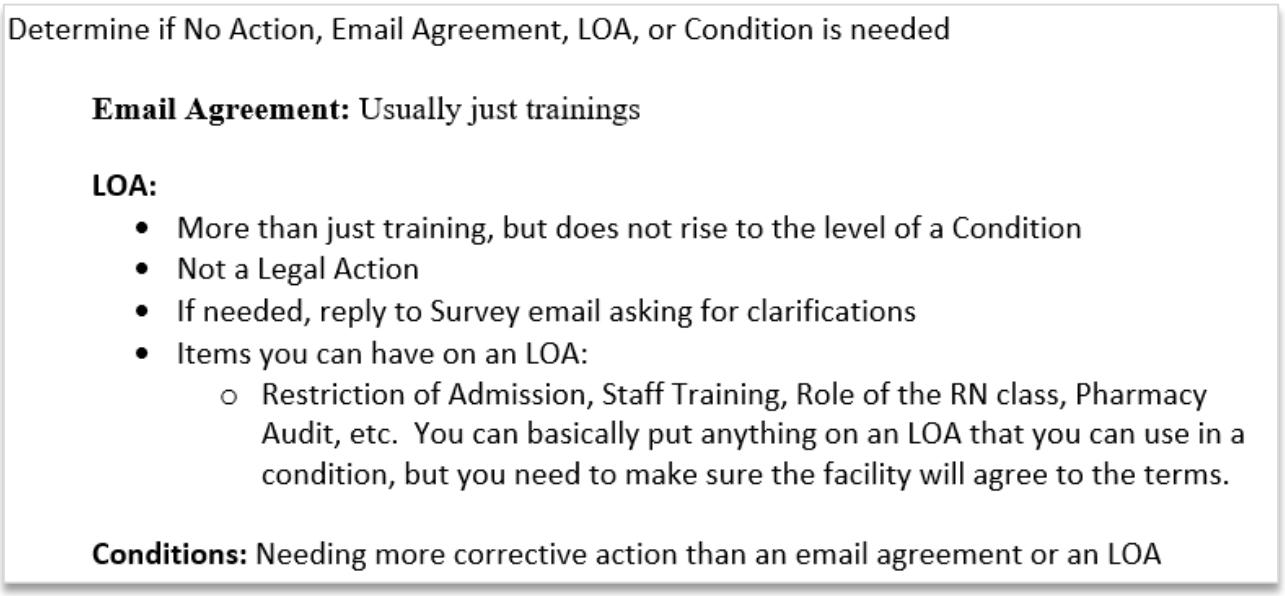
conditions in response to immediate jeopardy as mandated by statute. According to ORS 441.736, the Department has the authority to ("may") issue a licensing condition when a rule violation is substantiated and is required to ("shall") impose a licensing condition in response to a finding of immediate jeopardy. ORS 441.736(2)(a) states:

> The department may impose a condition on the license of a residential care facility or long-term care facility in response to a substantiated finding of rule violation, including but not limited to a substantiated finding of abuse, and shall impose a condition on the license in response to a finding of immediate jeopardy, whether or not the finding of immediate jeopardy is substantiated at the time the license condition is imposed.

Despite this statutory requirement, multiple CBC staff members indicated that immediate jeopardy situations were not always followed up with a licensing condition. They further noted that a recent change in interpretation, and increased direction from leadership to issue conditions for immediate jeopardy findings, was perceived not as an effort to realign the unit with statutory expectations, but rather as a shift towards a more punitive enforcement style, which contrasts with what CBC staff identify their historical approach to be. One interviewee shared, "Before, when immediate jeopardy was cited, the [Corrective Action team] wouldn't always issue a condition; [CBC] would have a conversation to determine whether a condition was necessary. New interpretation is that they have to issue a condition whenever immediate jeopardy is cited." Another interviewee shared, "[Leadership] is taking a very punitive approach. Not how we operated in the past." In addition to these accounts of implemented practice, current procedures and training materials for the CBC unit responsible for finalizing licensing conditions do not include a reference to the requirement to issue a condition in response to immediate jeopardy. As a result, confirmed health and safety concerns at facilities may not have been formally addressed with a licensing condition. This lack of action underscores the need for updated protocols to ensure that all immediate jeopardy situations are promptly and appropriately managed.

To be able to successfully impose a condition in response to immediate jeopardy, the Department must be able to consistently and reliably make an immediate jeopardy determination; however, multiple interviewees in CBC identified instances in which different units and different staff members reached diverging opinions about an immediate jeopardy determination. Staff members noted a perceived pressure from leadership to classify situations as immediate jeopardy. Additionally, a CBC staff member shared that different units within CBC, survey and CAC, tend to reach different conclusions and have internal conflicts about

Figure 13. *CAC Training and Resource Guide* excerpt - determining corrective action



Determine if No Action, Email Agreement, LOA, or Condition is needed

Email Agreement: Usually just trainings

LOA:

- More than just training, but does not rise to the level of a Condition
- Not a Legal Action
- If needed, reply to Survey email asking for clarifications
- Items you can have on an LOA:
  - Restriction of Admission, Staff Training, Role of the RN class, Pharmacy Audit, etc. You can basically put anything on an LOA that you can use in a condition, but you need to make sure the facility will agree to the terms.

Conditions: Needing more corrective action than an email agreement or an LOA

whether a situation is immediate jeopardy or not. This perceived lack of consistency indicates that SOQ may struggle to appropriately triage facility issues, which suggests that SOQ does not position itself well to apply the mandated enforcement strategies. There is consistent definition of immediate jeopardy across state statute and federal guidance, as well as ample, recently updated federal guidance, about how to make an immediate jeopardy determination. Despite this, A&M was unable to identify any practice documents or training materials that provide staff guidance on how to make this determination.

A final indication that the CBC team is out of alignment with these statutory requirements is the reliance on emails and Letters of Agreement (LOA) to

document informal corrective action strategies. A review of a CBC training guide, shown in Figure 13. *CAC Training and Resource Guide* excerpt - determining corrective action, shows that the CBC team implements an enforcement strategy where staff decide, based on survey and/or investigation findings, that a facility should receive an email, a LOA, or a licensing condition. Included in the email agreement and the LOA descriptions are items that statute identifies as licensing conditions. ORS 441.367(1)(b) includes a non-exhaustive list of potential licensing conditions. Included in this list are "Requiring additional training for staff" and "Restriction on admissions." By choosing to pursue these actions through emails and LOAs rather than a formal licensing condition, the Department creates the potential for bias, makes itself beholden to provider agreement with proposed next steps, and potentially circumvents some administrative process requirements outlined in statute while decreasing transparency of the regulatory process. Additionally, pursuing corrective action through informal means, like undocumented technical assistance or a LOA, weakens the Department's ability to track and trend compliance issues across the system.

Meeting Complaint Investigation Timelines in Nursing Facilities

The state requirement that ODHS shall cause an investigation to begin within two hours in the most extreme health and safety situations (ORS 441.650), and by the end of the next working day for less critical health and safety allegations is not currently being met by NFSU. These requirements are significantly more stringent than comparable federal requirements issued by CMS that require an investigation within 3 business days for Immediate Jeopardy complaints / facility-reported incidents and within an average of 15 business days for non-IJ High Priority from receipt of the initial report, not to exceed 18 business days.[14] Multiple interviewees from within NFSU highlighted the differences in these requirements, and shared that the more immediate response required by state statute felt

[14] The federal IJ category requires that "there continues to be an immediate risk of serious injury, harm, impairment or death of a patient or resident unless immediate corrective action is taken", which is not required under the state definition. Non-IJ-High Priority is defined as "if the alleged noncompliance with one or more requirements may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well-being that a rapid response by the SA is indicated." State Operations Manual, Chapter 5 – Complaint Procedures, 5075.1 and 5075.2.

impossible to meet due to lack of adequate staffing and the geography of the state and drive times from SOQ offices to facility locations.[15] The lack of alignment in investigation response requirements as well as the definitions of these types of complaints make it challenging for NFSU to meet both the state and federal requirements.[16] The lack of definitional alignment / prioritization on types of complaints and incidents creates unnecessary challenges for SOQ to balance whether state or federal guidance should take precedence.

The Oregon abuse investigation response timelines have been in state statute since at least the 1990s. However, the operational responsibility for completing these investigations has changed from APS to SOQ in recent years, driven by federal expectations. This change is significant because nationally APS programs are recognized for their quick (measured in hours) response times, typically enabled by local offices distributed throughout the jurisdiction. NFSU does not have local offices throughout the state. In 2018, a Government Accountability Office (GAO) audit found that a failure in CMS oversight allowed ODHS to improperly implement APS investigations in response to abuse allegations in nursing homes, rather than responding to these allegations with an investigation by the state survey agency, APD (SOQ) as required federally. Following that audit, CMS and ODHS worked together to transition the investigation responsibility to SOQ. As of 2024, interviewees from SOQ reported to A&M that with current staffing resources, they are unable respond to abuse investigations as required and lack the “rapid response” expertise that is typically associated with APS. A possible explanation for the delayed response times is that ODHS has not properly adjusted resources to respond to the federal expectation that abuse investigations be completed by SOQ, and the state expectations that investigations begin within a few hours.[17]

[15] A&M observed an underlying assumption within these discussions that NFSU has interpreted the state statutory requirement to mean that an on-site investigation presence is expected within the given timeframes. This is likely because CMS specifically requires an onsite survey in IJ and Non-IJ High complaints / incidents.

[16] It should be noted that if states do not meet CMS requirements, CMS has the authority to levy penalties for noncompliance.

[17] GAO Audit Letter. https://www.gao.gov/assets/gao-19-313r.pdf

Despite the difficulty meeting state standards, tracking SOQ performance against federal standards shows success for the NFSU unit. SOQ, as the state survey agency, participates in the federal State Performance Standards System (SPSS) program. One metric included in the SPSS measures the number of immediate jeopardy intakes that were initiated in alignment with the federal standards (2 days). A state is considered to have "met" this performance measure if at least 80% of these intakes have been made on time. In the most recently published SPSS reports, Oregon demonstrates that they have met this requirement.[18] However, Oregon's response times for lower tier complaint responses are less successful. According to public reporting, as of mid-December, SOQ's response time for high priority complaints that were not immediate jeopardy averaged 115 days, far exceeding both the federal and state benchmarks.[19]

In an effort to balance federal and state expectations, and to improve complaint response times, SOQ has recently tried to outline for staff and CMS a triaging approach. This approach includes NF unit staff working on high priority complaints as requested by CMS and also on lower-level complaints to remain responsive to state priorities. This dual approach was formally documented in an internal memo in December of 2024, and its effectiveness and success cannot yet be determined.

Prior to this dual approach, the SOQ NFSU unit maintained focus on meeting federal expectations and ensuring facility compliance with CMS standards, but the state expectation for rapid intervention in situations of abuse was not achieved.

Management of Adult Foster Homes

While the most common assessment of the AFH unit was that this group within SOQ was able to successfully align operations with legislative mandates, some interviewees did report misalignment in certain areas. ORS 443.775 establishes high-level compliance standards for adult foster homes. These expectations are enforced through licensing surveys conducted by local offices and corrective

[18] "Fiscal Year 2023 (FY23) State Performance Standards System (SPSS) Findings," Center for Clinical Standards and quality, August 1st 2025, https://www.cms.gov/files/document/admin-info-24-20-all.pdf

[19] "'That's Unacceptable': How Delays, Backlogs plague Oregon's nursing home Inspection Unit," Oregonian Watchdog, February 7th 2025, https://www.oregonlive.com/watchdog/2025/02/thats-unacceptable-how-delays-backlogs-plague-oregons-nursing-home-inspection-unit.html

action impositions carried out by the SOQ central office. Multiple interviewees with expertise in adult foster homes noted inconsistencies between county staff and SOQ central office staff when making decisions about facility sanctions or licensing actions. Additionally, one SOQ staff member commented that they believed themselves able to identify an impact of personal preference for specific licensees on licensing survey outcomes when reviewing licensing survey reports completed by AFH staff in local offices.

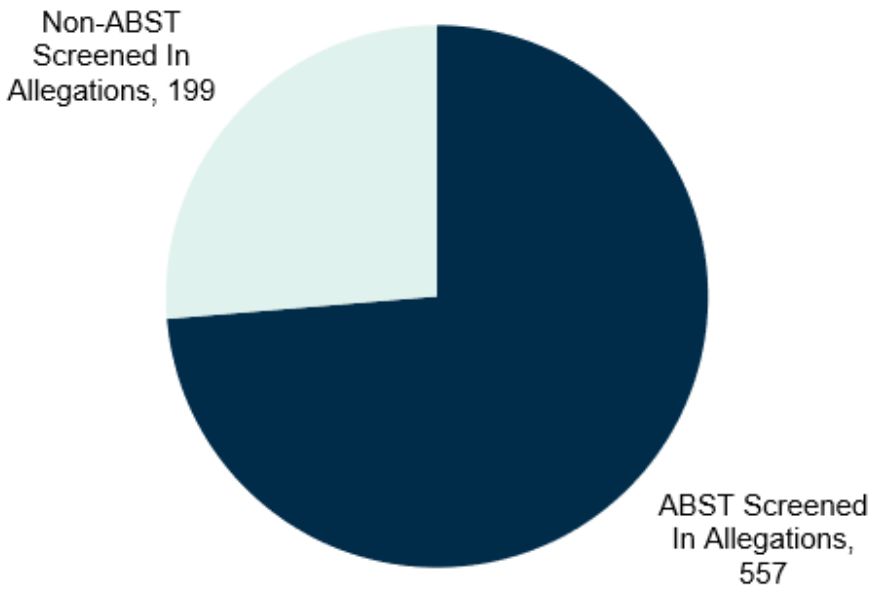
CBC Complaint Investigations

While CBC's Licensing Complaint Unit (LCU) does complete facility investigations, the delayed response times reported by SOQ staff, and the large backlog (4000+), indicate that the unit is not in alignment with the statutory expectation that investigations begin without "undue delay." Instead, SOQ staff report that some complaints have been left uninvestigated for multiple years. As of January 2024, the CBC Unit had a complaint backlog of over 4000 complaints.

When asked about why response timelines can sometimes stretch beyond the expected duration, staff reported understaffing and increased workload as primary drivers of the delays. The increased workload was attributed to a backlog that developed during the COVID-19 pandemic and implementation of the Acuity Based Staffing Tool (ABST) which has led to an increased number of investigations related to adequate staffing. ORS 443.441 requires that the Department respond to complaints of harm or understaffing by assessing staffing levels and completing a report that includes findings and evidence for each incident alleged in the complaint. Operationally, many complaints that are submitted to APS often result in an LCU ABST allegation that the unit must respond to. Staff report struggling to implement this expectation, noting the high-administrative burden of documenting evidence for each incident within a complaint and the challenges both facilities and SOQ staff have in interacting with the ABST. Data from December 2024 shown in Figure 14. December 2024 new CBC complaint investigations by type (n=756) shows that 75% of the total new allegations were ABST related. CBC received 557 new ABST allegations in one month, while the unit only manages around 570 facilities total. This large volume seems to indicate that

not only are there process management challenges, there may also be a case-management or a case initiation challenge where the origination of new complaints may not be providing meaningful signal of compliance challenges at facilities.

Figure 14. December 2024 new CBC complaint investigations by type (n=756)



SOQ staff also shared that they do not view LCU current policies and procedures as adequate to guide their work. “I want to do a good job,” said one interviewee as they shared that they had not been trained to do what is currently being asked of them. A&M was provided with a staff manual that provides guidance to LCU staff about how to complete complaint investigations, and observed several areas where additional detail would be helpful. Figure 15. Excerpt from investigation guidance included in the *LCU Complaint Process Guide* shows the level of detail provided in the guide regarding what steps an investigator should take to complete an investigation. The guide includes vague phrases such as, “potential root causes,” “refer as appropriate,” and “as applicable.” The guide does not include examples of typical evidence, root causes, or emergent concerns that are often observed during LCU investigations. It also does not include observational guidance to surveyors about which elements of the physical environment or service delivery to observe. For comparison, Figure 17. Excerpt from investigation

guidance included in the CMS provides an example of comparable guidance issued by the federal government about how investigations should occur in nursing facilities. This document includes a greater level of detail and relevant examples.

Figure 15. Excerpt from investigation guidance included in the *LCU Complaint Process Guide*

6. Observe the facility environment, facility staff, and residents as applicable and useful to the review to assess specific tasks, systems or areas related to the complaint as well as to identify potential root cause.
7. Keep the review focused on the complaint(s). At times other serious concerns will be identified in the course of the review. Follow up on those concerns as needed or refer as appropriate.
8. Request access to all known documents needed as applicable for review, including but not limited to:
    - Policies and procedures;
    - Medication administration records;
    - Resident care plans;
    - Staff training records; and
    - Maintenance and repair records.

Figure 16. Excerpt from investigation guidance included in the CMS issued *State Operations Manual*

> Observe the physical environment, situations, procedures, patterns of care, delivery of services to residents, and interactions related to the complaint. Also, if necessary, observe other residents with the same care need. After determining what occurred, i.e., what happened to the resident and the outcome, investigate what facility practice(s) or procedures affected the occurrence of the incident.
>
> EXAMPLE
>
> It was verified through the investigation that a resident developed a pressure sore/ulcer which progressed to a Stage IV, became infected and resulted in the resident requiring hospitalization for aggressive antibiotic therapy. Observe as appropriate: dressing changes, especially to any other residents with Stage III or IV pressure sores; infection control techniques such as hand washing, linen handling, and care of residents with infections; care given to prevent development of pressure sores (e.g., turning and repositioning, use of specialized bedding when appropriate, treatments done when ordered, keeping residents dry, and provision of adequate nutritional support for wound healing).

LCU and APS share responsibility for investigations within CBC-managed facilities. APS responds to abuse investigations, while LCU responds to allegations of harm that is not abuse, allegations of insufficient staffing, community complaints, or to requests from political leaders for investigations into certain facilities. If LCU is unable to respond to some complaints for multiple years, that leaves families and residents without sufficient recourse in potentially dangerous situations that are not abuse, allowing facilities with significant allegations affecting the health and safety of its residents to continue operating without restrictions.

Figure 17. Findings Summary | Policy Alignment contains a summary of the findings included in this section.

Figure 17. Findings Summary | Policy Alignment

ID	Finding	Evidence	Implication
11	The CBC unit's licensing condition practices demonstrate a low level of alignment	• Staff interviews that share that the CBC unit has not consistently issued conditions as required by statute	• SOQ's ability to track and trend provider compliance is weakened.

ID	Finding	Evidence	Implication
	with state statutory expectations.	• Lack of practice documentation and/or training materials that show a clear expectation for staff to issue conditions in response to immediate jeopardy • Practice documentation and training materials that show that the CBC unit rely on alternative enforcement strategies, rather than conditions	• SOQ's ability to make an objective decision about necessary corrective next steps is weakened.
12	The SOQ team reports challenges making immediate jeopardy determinations, weakening their ability to comply with statutory expectations.	• Staff interviews that share that CBC struggles to make immediate jeopardy determinations • Lack of practice documentation and/or training materials that show how CBC staff make immediate jeopardy determinations	• Health and safety is not consistently upheld across SOQ. • Resource efficiency is compromised.
13	Recent changes to which unit within ODHS conducts abuse investigations has contributed to delayed response times in Nursing Facilities	• Staff interviews that indicate a lack of expertise and resources necessary to initiate investigations within 2 hours • Review of GAO audit findings and recommendations • Public reporting on investigation delays for Tier 2 complaints • Review of requirements in ORS 441.650	• Abuse investigations for vulnerable residents are not initiated as promptly as expected by state law.
14	The CBC unit does not complete timely investigations.	• Staff interviews that report untimely response times. • Review of SOQ training materials • Review of requirements in ORS 443.441.	• Complaint investigations for vulnerable residents are not initiated as promptly as expected by state law.
15	The CBC unit may not have clear procedures in place regarding how to determine if a	• Review of the CAC procedure guide • Review of ORS 443.425 & ORS 443.436	• Facilities that pose significant health and safety risk may not have appropriate

ID	Finding	Evidence	Implication
	facility is or is not in substantial compliance.		licensing actions taken against them.
16	The AFH unit may not complete fully impartial surveys.	• Reports from interviewees.	• Providers may not experience fair and impartial reviews. • Health and safety for residents may not be prioritized over the provider perspective.
17	The CBC unit does not complete timely licensing renewal surveys.	• Reports from interviewees	• Providers with compliance challenges may not be identified/ corrected until a resident or family member files a complaint

VII. Enhancement Considerations

Suggested Urgent Improvements

A&M has found that the SOQ team, although well-intentioned and staffed with experienced frontline staff, struggles to keep up with the core work expected of a licensing unit such as completing timely licensing renewals and complaint investigations. Some long-term solutions such as statutory changes, increased FTE allocation, reclassifications of staff, and the restructuring of the CBC licensing process are needed to improve SOQ's functioning.

In the short term, A&M recommends that SOQ pursue the following actions.

1. **Implement clear Immediate Jeopardy decision making protocols for the CBC unit.** The determination of whether a situation is or is not immediate jeopardy is of critical importance to SOQ and the residents they protect. It impacts how quickly staff respond to a situation and how punitive associated corrective actions are. A&M recommends the fast-tracking of SOQ current efforts to develop a new Immediate Jeopardy protocol, and that the new protocols are rolled out in adherence with change management standards. A change of this impact will be implemented most successfully if staff are involved in decision making, have the ability and the resources necessary to implement the change, and have adequate reinforcement about the change after it is implemented. Additionally, SOQ should monitor implementation and the results of these changes as they are rolled out to make sure that a positive impact is realized.
2. **Revise Letter of Agreement Structure.** LOAs are currently a formalized, informal response to substantiated non-compliance. This response exists outside of the formal licensing structure which includes surveys reports and findings, investigation reports and findings, statement of deficiencies, corrective action plans, and conditions. LOAs introduce data integrity issues and reduce public transparency about facility performance. A&M recommends that an urgent review of LOA usage be completed to determine if and when LOAs should continue to be used, and that SOQ

develop new expectations regarding how to respond to substantiated non-compliance that prioritize formal licensing actions.

3. **Complete team review of statutes and recommendations (Workshops).** Staff report feeling confused and overwhelmed by the expectations of their jobs. A&M recommends that CBC leadership organize workshops oriented around developing a shared understanding of existing statutory requirements and regulatory opportunities. A diverse group of staff should be brought together to review statutory and regulatory expectations and, as needed, develop or improve operating procedures to address these expectations. Additionally, these working sessions should aim to identify develop a regulatory agenda for SOQ to undertake over the next 1-3 years. These working sessions should be in-person and include the decision makers necessary to reach final determinations on process.
4. **Invest in staff morale and improve internal communications.** One of SOQ's greatest assets is the experience of its frontline staff. However, the high-stakes of the impact of their work, lack of confidence in their management structures, and the high-degree of scrutiny that they face from the public and government partners have decreased morale. A&M recommends that SOQ leadership implement new communications protocols that include intentional engagement with staff, opportunities for collaborative decision making, and clear expectations for middle management in-terms of how and when information is disseminated throughout the organization.
5. **Increase supports for and reorganize the CBC team.** The CBC team is under resourced compared to its peer subunit within SOQ (NF) and is facing some of the largest compliance challenges. A&M recommends that SOQ leadership evaluate all possible avenues for acquiring additional personnel resources for CBC, even on a temporary basis. Options include reassigning staff from other facility verticals, receiving reassigned staff from other units within APD or ODHS, evaluating options for reclassifying vacancies, or temporarily reinvesting turnover savings in contracted staff.
6. **Investigate needed personnel investments.** Evidence indicates that SOQ may lack the necessary resources to complete their assigned work. While

process improvements should be pursued, SOQ should, in parallel, complete an updated workload model analysis to determine what level of staffing resources are needed to meet current expectations. Additionally, A&M recommends that at least one personnel resource be devoted to managing the HR process and onboarding tasks necessary to efficiently fill vacancies and/or new positions.

7. **Investigate potential reorganization of OPAs (operations & policy analyst).** Evidence suggests that the current expectation that OPAs provide technical assistance to a caseload of providers creates internal conflicts of interest within SOQ. A&M recommends that SOQ undertake a thorough review of the OPA workload and impact, including engagement with provider stakeholders, to reach a final determination on what operating structure will best leverage the OPA skill set to promote resident safety. A&M recommends that peer review of state operating models for comparable organizations be considered as a part of this review.
8. **Provide management and supervision support for middle managers and unit leaders.** Executive Leadership must communicate a vision to managers and supervisors and provide roadmaps for implementation of that vision. The interviews suggest that supervisors and managers are not well respected for their expertise in Department authority and the implementation of state regulations. Without consistent leadership at the supervisory and management levels, there will continue to be performance management issues and challenges with implementation of policies and procedures. Managers and supervisors have also expressed frustration and challenges with understanding and / or meeting the expectations of Executive Leadership, which means that there must be stronger guidance and expectation-setting at every level, defining success and providing realistic guidelines on work effort and work load.

Legislative & Regulatory Actions

To address inconsistencies in expectations and to strengthen the statutory basis for SOQ's work, A&M recommends the following statutory actions.

1. **Remove all requirements for agreement between SOQ and Licensees regarding facility management decisions.** ORS 443.432 and ORS 441.333 require the Department to obtain agreement from the licensee before imposing a licensing condition related to staffing levels or pursuing appointment of a temporary manager. These stipulations weaken the Department's authority over licensees, confuse the Department's role as a regulatory body, and potentially disrupt critical enforcement activities meant to ensure resident health and safety. A&M recommends that these provisions, along with any other provisions that require licensee agreement with enforcement actions, be removed from statute. This recommendation addresses Finding #5.
2. **Establish performance-based licensing durations for CBC facilities and AFHs.** ORS 443.735(7) establishes a 1-year duration for AFH licenses. ORS 443. ORS 443.425(1) establishes a 2-year duration for CBC licenses. Flat licensing durations and corresponding inspection timelines do not allow for flexibility regarding Department resource allocation. A&M recommends that the legislature revise ORS 443 to allow the Department the flexibility to issue licenses for durations of 6 months to 36 months, depending on provider performance. This flexibility would allow the Department to invest more resources in ensuring compliance at facilities with known poor performance. This recommendation addresses Finding #14 and Finding #17.
3. **Consider investment in backlog clearing resources.** Regardless of the root cause, both NFSU and CBC struggle with a large backlog of complaints. Both units report responding to complaints after the resident involved is deceased. While staff respond to stale complaints, where interventions are likely much less impactful due to changes in resident status and facility ownership, newer complaints are left to age. A&M recommends that Oregon make an investment in additional staff resources, on at least a temporary basis, to help SOQ clear the backlog, so that new complaints have a better chance of being addressed in a timely manner. This should be done in conjunction with a triage process, so that the complaints that are most critical are addressed first. Additionally, workload model assumptions

should be reassessed to determine if additional resources or reclassifications are needed for SOQ to keep up with the expected volume of complaints once the backlog is cleared. This recommendation addresses Finding #14.

4. **Clarify expectations regarding licensing suspension and interim management of facilities.** ORS 443.421 and ORS 441.333 both include procedures for establishing interim management of a facility. These procedures are not aligned. A&M recommends that these provisions be revised to reflect legislative intent regarding when interim management should occur, and how that overlaps with licensing suspension. This change should not be pursued without the acceptance and pursuit of Recommendation #1. This recommendation addresses Finding #5.
5. **Change requirements related to immediate jeopardy condition issuance.** ORS 441.736 includes requirements to issue conditions in response to immediate jeopardy. The statute is not clear regarding if a condition is issued when immediate jeopardy is alleged or substantiated. A&M recommends that this mandate be transitioned into an authority for immediate jeopardy situations that have been resolved by the time of substantiation, so that SOQ may exercise discretion about when a condition is appropriate. At times, immediate jeopardy situations are rectified by the time the allegation is substantiated, and the requirement for condition issuance can sometimes create additional administrative burden. Additionally, A&M recommends that the statute be revised so that clarity is added about if SOQ is required to issue a condition before immediate jeopardy is substantiated. A&M recommends that SOQ continue to make findings and issue investigation reports with those findings in these instances. This recommendation addresses Finding #11 and Finding #12.
6. **Review civil penalty structure and consider updates.** ORS 441.731 includes a framework for the civil penalties that SOQ must impose on facilities based on the violation's severity and scope. Civil penalties for substantiated abuse are not to exceed $40,000 for all violations occurring in a facility within a 90-day period. A&M recommends that financial analysis be completed to

compare average civil penalty amounts within a year against facility revenues. One option is to create an assessment determination factor based on agency size. Civil penalties are the primary enforcement action pursued by the CBC team, and if they are not a sufficient deterrent then facility non-compliance may continue. This recommendation addresses a promising practice as established by the Biden administration in 2021.

7. **Revise documentation expectations for staffing related complaint investigations.** ORS 443.441 requires that CBC complaint investigators write an investigation report that includes "factual basis for findings for each incident… alleged in the complaint." A&M recommends that the reference to "each incident" be removed, so that SOQ staff have the flexibility to group incidents into problem areas rather than reiterating evidence and findings at an incident level. (This recommendation should not be taken to mean that civil penalties should not continue to apply at the incident level.) This recommendation addresses Finding 14.
8. **Clarify timing expectations for CBC facilities and AFHs.** ORS 443.767 and ORS 443.441 include vague expectations for complaint response times. A&M recommends that these statutes be revised to include specific parameters for when an on-site presence is expected in response to an allegation, based on the severity of the allegation. Nationally, response time expectations tend to vary between 24-hours and 7 days, with many states choosing to set triage expectations.[20] This recommendation addresses Finding #4.

Other

SOQ faces challenges in meeting workload demands – workload demands that are directly related to ensuring resident safety. However, additional analysis is needed before recommendations beyond urgent actions and these statutory changes can be made about how best to improve SOQ's efficiency and effectiveness. Potential interventions include the following:

[20] National APS TA Resource Center Report - https://pfs2.acl.gov/strapib/assets/APSTARC_Evaluation_Long_7315e2724d.pdf

1. Investing in additional personnel resources.
2. Reorganizing SOQ staff.
3. Completing efficiency-focused, collaborative process evaluations and implementing changes.
4. Strategically aligning state requirements with federal requirements.
5. Investing in prevention practices with the goal of reducing complaint volume.
6. Focusing on improving operational capabilities such as communication pathways and accountability structures (expectation setting, performance tracking, and discipline measures).
7. Strengthening SOQ business processes like policy development and change management.
8. Developing/updating some SOQ internal operating procedures and training resources for staff, such as providing enhanced clarity on Immediate Jeopardy determinations.

A&M is in the process of completing additional analysis and will release final recommendations in April of 2025.

VIII. Conclusion

This report is based on information collected as of January 2025. The project is ongoing and will continue through April 2025. Upcoming work includes a comprehensive SWOT analysis and a final report that will include detailed implementation planning. These future deliverables will provide further insights and actionable recommendations to support the SOQ unit in achieving its mission.

Appendix One | Findings Summary Table

ID	Finding	Evidence	Implication
1	The distribution of state legislative requirements is uneven across different provider types and operational area managed by the SOQ unit.	• Statutory Review and Analysis • **Error! Reference source not found.**	• SOQ staff will need varying levels of policy and operational analysis skills depending on what facility type they manage.
2	The Department is given consistent guidance about what to prioritize in facility management (resident wellbeing, not overly punitive approach).	• Statutory analysis of ORS 441 & ORS 443 • Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type	• While the high-level approach is clear, the implementation strategy to achieve this goal is not. SOQ staff and management are put in the position of navigating the degree of punitive that will be most effective/ well-received at any given time.
3	The Department must respond to varying operational expectations based on facility types.	• Statutory Review and Analysis • Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type	• SOQ staff will need varying levels of policy and operational analysis skills depending on what facility type they manage.
4	Some unclear statutory expectations are not further detailed in Department rule.	• Statutory analysis of ORS 443.441 & ORS 443.767 • Administrative rule analysis of OAR 411-054 7 OAR 411-052	• SOQ has not established clear consumer protections regarding response times for CBC and AFH investigations.
5	The Department must navigate overlapping authorities and mandates within certain operational areas.	• Statutory analysis of ORS 441.333 & ORS 443.421 • Figure 5. Summary of SOQ key state statutory mandates and authorities by operational area and facility type	• SOQ has not established a systematic, Department-led approach to licensing revocation and interim facility management.

ID	Finding	Evidence	Implication
5.5	The Department must navigate federal and state requirements that are not always in alignment and are challenging to comply with simultaneously.	• Statutory analysis of ORS 441 • Review of CMS Mission and Priorities Document 2025 • Review of internal SOQ policy document describing prioritization approach (Dec 2024)	• The operational structure of NFSU is based on federal requirements, which can create conflict with state expectations (e.g., federal prioritization of surveys and Type A complaints v. state complaint categories that do not align with federal definitions).
6	SOQ staff self-report a low level of alignment between legislative mandates and CBC operations.	• Interview data as summarized in Figure 7.	• CBC interactions with facilities are likely to be inconsistent. • Key expectations established by the legislature may not be met.
7	SOQ staff self-report a high level of alignment between legislative mandates and AFH operations.	• Interview data as summarized in Figure 7.	• AFH interactions with facilities are likely to be consistent.
8	SOQ staff self-report a high level of alignment between legislative mandates and NF operations. However, they note a lower degree of alignment between operations and state expectations, compared to federal expectations.	• Interview data as summarized in Figure 7.	• Nursing facility federal expectations are likely to be met. • Nursing facility state expectations are less likely to be met.
9	Staff report that policy interpretations tend to change each time new SOQ leadership is established, potentially compromising operational consistency and the staying power of various reforms.	• Interview data	• Strong change management practices are needed, otherwise new initiatives will not be implemented to fidelity. • Implementing a new change via a state regulation or statutory change are likely to have

ID	Finding	Evidence	Implication
			more staying power across administrations.
10	SOQ staff is more experienced than SOQ middle management, which could cause conflicts and change-management related friction.	• Self-reported tenure as documented in interview notes	• Tension is likely to exist between middle managers and their staff. • Additional support may be needed to help new 6managers come up to speed. • Strong communication practices are needed.
11	The CBC unit's licensing condition practices demonstrate a low level of alignment with state statutory expectations.	• Staff interviews that share that the CBC unit has not consistently issued conditions as required by statute • Lack of practice documentation and/or training materials that show a clear expectation for staff to issue conditions in response to immediate jeopardy • Practice documentation and training materials that show that the CBC unit rely on alternative enforcement strategies, rather than conditions	• SOQ's ability to track and trend provider compliance is weakened. • SOQ's ability to make an objective decision about necessary corrective next steps is weakened.
12	The SOQ team reports challenges making immediate jeopardy determinations, weakening their ability to comply with statutory expectations.	• Staff interviews that share that CBC struggles to make immediate jeopardy determinations	• Health and safety is not consistently upheld across SOQ. • Resource efficiency is compromised.

ID	Finding	Evidence	Implication
		• Lack of practice documentation and/or training materials that show how CBC staff make immediate jeopardy determinations	
13	Recent changes to which unit within ODHS conducts abuse investigations has contributed to delayed response times in Nursing Facilities.	• Staff interviews that indicate a lack of expertise and resources necessary to initiate investigations within 2 hours • Public reporting on investigation delays for Tier 2 complaints • Review of GAO audit findings and recommendations • Review of requirements in ORS 441.650	• Abuse investigations for vulnerable residents in Nursing Facilities are not initiated as promptly as expected by state law.
14	The CBC unit does not complete timely investigations.	• Staff interviews that report untimely response times. • Review of SOQ training materials • Review of requirements in ORS 443.441.	• Complaint investigations for vulnerable residents are not initiated as promptly as expected by state law.
15	The CBC unit may not have clear procedures in place regarding how to determine if a facility is or is not in substantial compliance.	• Review of the CAC procedure guide • Review of ORS 443.425 & ORS 443.436	• Facilities that pose significant health and safety risk may not have appropriate licensing actions taken against them.

ID	Finding	Evidence	Implication
16	The AFH unit may not complete fully impartial surveys.	• Reports from interviewees.	• Providers may not experience fair and impartial reviews. • Health and safety for residents may not be prioritized over the provider perspective.
17	The CBC unit does not complete timely licensing renewal surveys.	• Reports from interviewees	• Providers with compliance challenges may not be identified/ corrected until a resident or family member files a complaint

Appendix Two | Catalogued Policies & Procedures

Policy Name	Applicable Provider Type	Applicable Functional Category
IBLs and bedrails process for APD AFH	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Additional Policy Updates per the AFH 2023-2024 Collective Bargaining Agreement	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
AFH 2023-2025 Collective Bargaining Agreement Impacts for AFH Exceptions	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
APD AFH Public Disclosure File	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Submission of move-out notices to SOQ	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Deidentifying AFH licensing reports	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
APD AFH Licensing Visits	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)

Policy Name	Applicable Provider Type	Applicable Functional Category
APD AFH Licensing Complaints	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
AFH Rate Increase Mis-Print on Checks and Remittance Advice	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
AFH 2021-2023 Collective Bargaining Agreement Impacts	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
AFH Hospital Discharge Incentive Payment	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
APD AFH Sprinkler Status in ASPEN	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
AFH Standard Ventilator Rate Requests	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
APD Adult Foster Home Online Payment Website is Available	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Mask requirements for AFH Providers	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)

Policy Name	Applicable Provider Type	Applicable Functional Category
COVID-19 Vaccine Support and Follow-up for AFH	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Data entry for private pay AFH licensees	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Required APD AFH enrollment for new placements of APD consumers in DD AFH	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Adult Foster Home and PACE Rates	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
HCBS Limited License Adult Foster Homes	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
AFH Licensing Clarification on APD AFH Licensee's Responsibilities regarding RN Delegation	Adult Foster Homes	Day-to-Day Ops (Including Directions about Provider Management)
Notification of New Ventilator AFH License Applications	Adult Foster Homes	Initial Licensing Applications
Review of Vaccine Documentation in APD AFH	Adult Foster Homes	Initial Licensing Applications

Policy Name	Applicable Provider Type	Applicable Functional Category
Adult Foster Home Medicaid Provider Revalidation	Adult Foster Homes	Ongoing Licensing Reviews
APD AFH License Renewals post-COVID	Adult Foster Homes	Ongoing Licensing Reviews
Virtual Visit for AFH License Renewals	Adult Foster Homes	Ongoing Licensing Reviews
Pending APD AFH licenses requiring reneal due to COVID-19	Adult Foster Homes	Ongoing Licensing Reviews
APS Eligibility in Facilities (APD, DD, and BH): 1	Community Based Care	Complaints & Investigations
APS Eligibility in Facilities (APD, DD, and BH): 2	Community Based Care	Complaints & Investigations
Adult Protective Services: Eligibility for APS from APD in Licensed Facilities	Community Based Care	Complaints & Investigations
APS: Licensing Referrals in APD-Licensed AFH, RCF, and ALF Settings	Community Based Care	Complaints & Investigations
APS: Referrals to the Licensing Complaint Unit	Community Based Care	Complaints & Investigations
APS Access to Facility Records in ALF, RCF, and AFH Settings	Community Based Care	Complaints & Investigations

Policy Name	Applicable Provider Type	Applicable Functional Category
New APS Policy 120-003-APS Access to Records in ALF, RCF, and AFH Settings	Community Based Care	Complaints & Investigations
Acuity-Based Staffing Tool (ABST) Six-Month Monitoring	Community Based Care	Corrective Action Management
Acuity-Based Staffing Tool (ABST) APS List	Community Based Care	Corrective Action Management
Cannabis acquisition and administration in long-term care settings	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
New CBC (AFH/RCF) Exception & AFH Standard Vent Email Box	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
Fire and Life Safety Training Update	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
Resources to assist APD AFH Providers in Accessing PPE	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
Visitor Restrictions for LNF, RCF, ALF, and AFH due to COVID-19	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
Survey Monkey closing May 31, 2017 for reporting HCBS AFH	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)

Policy Name	Applicable Provider Type	Applicable Functional Category
Compliance (Exception: Multnomah County)		
Communication to CBC Providers Regarding Individually Based Limitations	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
Community Based Care Team Program Procedure for 30 Day Move Out Notice	Community Based Care	Day-to-Day Ops (Including Directions about Provider Management)
Community Based Care Team Program Procedure for (Interim) Department Review of Proprietary Acuity-Based Staffing Tools	Community Based Care	System QA (Trends, Oversight of SOQ Staff, Etc.)
Acuity-Based Staffing Tool (ABST) Facility Staffing Plan: OPA Procedure	Community Based Care	System QA (Trends, Oversight of SOQ Staff, Etc.)
Community Based Care Team Program Procedure for (Interim) Department Review of Proprietary Acuity-Based Staffing Tools	Community Based Care	System QA (Trends, Oversight of SOQ Staff, Etc.)
CMS QA for Medicare & Medicaid FY 2024 MPD	Nursing Facilities	Complaints & Investigations

Policy Name	Applicable Provider Type	Applicable Functional Category
Program Procedure: Revisit (RV) Protocol	Nursing Facilities	Complaints & Investigations
Complaint Intake / Triage Unit: Overview and SOPs	Nursing Facilities	Complaints & Investigations
COVID-19 Focused Infection Control (FIC) Survey Protocol	Nursing Facilities	Complaints & Investigations
Revisions to the Special Focus Facility (SFF) Program (QSO-23-01-NH)	Nursing Facilities	Corrective Action Management
Nursing Facility Federal/State Remedies Policies and Procedures	Nursing Facilities	Corrective Action Management
Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes	Nursing Facilities	Day-to-Day Ops (Including Directions about Provider Management)
Interim Final Rule - COVID-19 Vaccine Immunization Requirements for Residents and Staff (QSO-21-19-NH)	Nursing Facilities	Policy

Policy Name	Applicable Provider Type	Applicable Functional Category
Nursing Home Visitation - COVID-19	Nursing Facilities	Policy
Oregon Independent Informal Dispute Resolution (IIDR) Process	Nursing Facilities	Reportable Event Management
Independent Informal Dispute Resolution (I-IDR) Process: OR Long-Term Care Nursing Facility	Nursing Facilities	Reportable Event Management
NFSU Internal Protocol: Informal Dispute Resolution (IDR)	Nursing Facilities	Reportable Event Management
NFSU Internal Protocol: Informal Dispute Resolution (IDR)	Nursing Facilities	Reportable Event Management
Informal Dispute Resolution Process	Nursing Facilities	Reportable Event Management