Adult Foster Home Provider Alert

Policy updates, rule clarifications and announcements

Date: October 31st, 2022

To: APD Adult Foster Home Providers

From: Safety, Oversight and Quality Unit

Topic: ***Updated Frequently Cited Violations - Report**

****This provider alert has been updated to provide clarification. Updated information may be found below under the following: Violation: MARs: Immediately Initialed. The new information is underlined and italicized.**

The Safety, Oversight and Quality Unit will be running quarterly reports of the most frequently cited violations in adult foster homes (AFH) licensed with Aging and People with Disabilities (APD) to strengthen education and training for Licensees.

This report is meant to be a guideline for licensees so they are aware of current violation patterns and can conduct audits in the adult foster homes they operate. Questions about violations specific to your license should be sent to your licensor at the local licensing office.

Report dates: July 1, 2022 – September 30, 2022

HOME AND RECORDS VIOLATIONS

Violation: Care Plan: Review
OAR 411-051-0115 (2) The licensee or administrator must: Review and update each resident's care plan every six months.

Corrective Action: Care plans are to be updated at least every six months, or when the resident has had a change in condition. Changes in condition can include but are not limited to a significant decline in health

resulting in an increase of support, a hospitalization, an injury that changes support needs, changes in mobility or other needs related to their daily care and support. Updates must include the date the condition changed, the date of the update to the care plan, additional supports needed, and required signatures.

Violation: Facility Records: Proof Min Qualifications
OAR 411-050-0745 (1) FACILITY RECORDS. Completed facility records must be kept current, maintained in the AFH, and made available for review upon request. Facility records include but are not limited to: **(c)** Proof the licensee and all other caregivers have met and maintained the minimum qualifications at each home where they train or work, as required by OAR 411-049-0125.

Corrective Action: Licensors perform audits of caregiver's records, and it is the licensee's responsibility to ensure all records are on file as they relate to qualified caregivers. Caregiver qualifications can be found in OAR 411-049-0125.

Violation: Safety: Evacuation Drill
OAR 411-050-0725 (3) EVACUATION DRILL. An evacuation drill must be held at least once every 90 calendar days, with at least one evacuation drill per year conducted during sleeping hours.

Corrective Action: Practice evacuation drills are to be performed every 90 calendar days with one per year being conducted during sleeping hours. Midday naps are not counted as sleeping hours though the drill can be conducted not long after all residents have gone to bed or early in the morning, just as everyone is waking to start the day.

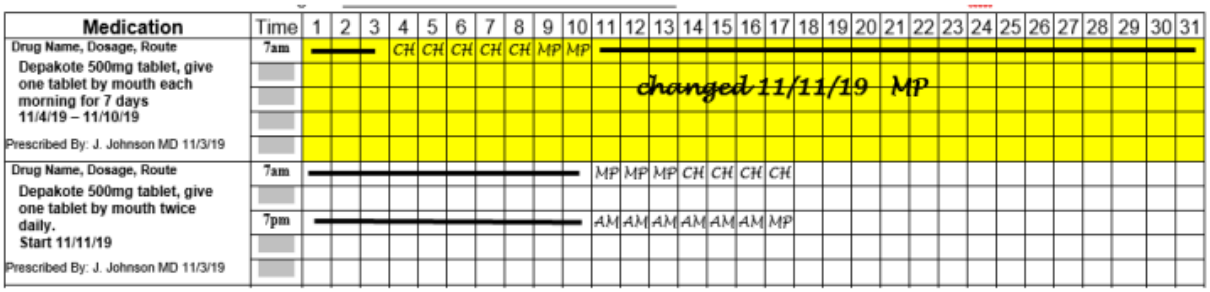
MEDICATION ADMINISTRATION RECORDS (MAR) VIOLATIONS
*All violations noted in this section are covered in the required training, Six Rights to Safe Medication Administration. Classes fill up quickly. Information on this training can be found here: https://www.oregon.gov/dhs/SENIORS-DISABILITIES/PROVIDERS-PARTNERS/Documents/training-calendar.pdf

Violation: MARs: Immediately Initialed
OAR 411-050-0130 (6) MEDICATION ADMINISTRATION RECORD. A current, written MAR, or electronic MAR (see OAR 411-050-0755(4)), must be kept for each resident and must: **(c)** Be immediately initialed by the caregiver administering the medication, treatment, or therapy as it is completed. A resident's MAR must contain a legible signature that identifies each set of initials.

Corrective Action: When medications are given, the MAR should be signed at the same time by the caregiver who administered the medication. *Licensees and caregivers should not be signing the MAR outside of the medication pass window when offering a medication to a resident,* as it increases the likelihood of medication mistakes being made. *There is a process for late entries on a MAR and, when there are delays in being able to chart, the late entry should be circled with a notation made on the back of the MAR as to the reason for the late entry. Charting late without noting the reason for the delay is considered falsification of records because it does not give a true and accurate representation of the medication pass.*

Violation: MARs: Changed Or Discontinued Orders
OAR 411-050-0130 (6) MEDICATION ADMINISTRATION RECORD. A current, written MAR, or electronic MAR (see OAR 411-050-0755(4)), must be kept for each resident and must: **(d)** Document changed and discontinued orders immediately showing the date of the change or discontinued order. A changed order must be written on a new line with a line drawn to the start date and time.

Corrective Action: Notations must be made on the MAR to indicate when a dosage has changed. Notice in the example below that the dates in the yellow box have a line drawn through to show that the medication is NOT to be given after the 10th and the new order below indicates the new dose is to start on the 11th.



Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Drug Name, Dosage, Route Depakote 500mg tablet, give one tablet by mouth each morning for 7 days 11/4/19 – 11/10/19 Prescribed By: J. Johnson MD 11/3/19	7am	—	—		CH	CH	CH	CH	CH	MP	MP	changed 11/11/19 MP																				
Drug Name, Dosage, Route Depakote 500mg tablet, give one tablet by mouth twice daily. Start 11/11/19 Prescribed By: J. Johnson MD 11/3/19	7am	—	—	—	—	—	—	—	—	—	—	MP	MP	MP	CH	CH	CH	CH														
	7pm	—	—	—	—	—	—	—	—	—	—	AM	AM	AM	AM	AM	AM	MP														

<u>Violation:</u> MARs: List & Identify Treatments

OAR 411-050-0130 (6) MEDICATION ADMINISTRATION RECORD. A current, written MAR, or electronic MAR (see OAR 411-050-0755(4)), must be kept for each resident and must: **(b)** Identify any treatments and therapies administered by a caregiver. The MAR must indicate the type of treatment or therapy and the time the procedure must be performed.

<u>Corrective Action:</u> A medication administration record (MAR) is to be kept for all residents.

<u>Violation:</u> MARs: PRN Medication: Parameters

OAR 411-050-0130 (7) PRN MEDICATIONS. Prescription medications ordered to be given "as needed" or "PRN" must have specific parameters indicating what the medication is for and specifically when, how much, and how often the medication may be administered. Any additional instructions must be available for the caregiver to review before the medication is administered to the resident.

<u>Corrective Action:</u> Parameters must be ordered and documented for medications prescribed as PRN, or “as needed.” Parameters must include what the medication can be given for (headache, leg pain, etc.), specific dose and specific frequency.

<u>Violation:</u> Medication Supplies

OAR 411-051-0130 (3) MEDICATION SUPPLIES. The licensee or administrator must have all currently prescribed medications, including PRN medications, and all prescribed over-the-counter medications available in the home for administration. Refills must be obtained before

depletion of current medication supplies. Attempts to order refills must be documented in the resident's record.

Corrective Action: Medications must be on hand for all meds on a resident's profile. If there are challenges in obtaining refills, document all attempts to have the medications refilled that includes the date of the attempt, who you contacted, how you contacted them (email, phone, etc.), and the results of each attempt. It is your responsibility to make sure medications are refilled in a timely manner (to the best of your ability) and that proper documentation is maintained.

Violation: Medication: Carry Out Orders
OAR 411-051-0130 (2) WRITTEN ORDERS. The licensee or administrator must obtain and place a signed order in the resident's record for any medications, dietary supplements, treatments, or therapies that have been ordered by a prescribing practitioner. The written orders must be carried out as prescribed unless the resident or the resident's legal representative refuses to consent. The prescribing practitioner must be notified if the resident refuses to consent to an order.

Corrective Action: Medication and treatment orders are to be carried out as written by the prescriber. If the resident declined a medication and/or treatment, first try to find out why the resident is declining. Questions to ask/concerns to look into are: Does it cause unwanted side effects? Does the resident not remember or understand the benefit? Could it be that the time of day the medication/treatment is scheduled is not congruent with the resident's daily schedule? Next, notify the provider what you have found as to why the resident is declining the medication and/or treatment and work with them to see if an alternative is available. Make sure you are documenting each step of this process, from when the medication and/or treatment is initially declined (and every time this happens), what you have found out regarding the declination, and notification to the provider.

Violation: Medications/Supplies/Patches: Disposal
OAR 411-050-0130 (10) DISPOSAL OF MEDICATION. Outdated, discontinued, recalled, or contaminated medications, including over-the-counter medications, may not be kept in the home and must be disposed of

within 10 calendar days of expiration, discontinuation, or the licensee or administrator 's knowledge of a recall or contamination. The licensee or administrator must contact the local DEQ waste management company in the home's area for instructions on proper disposal of unused or expired medications. Prescription medications for residents that have died must be disposed of within 24 hours according to section **(11)** of this rule. **(a)** TRANSDERMAL PATCHES. Used transdermal patches and unused patches, such as when the order was discontinued, or the patches have expired, must be folded in half with the sticky side together and disposed of as directed on the product information sheet or by the pharmacy.

Corrective Action: Properly dispose of medications and transdermal patches as indicated by rule within 10 calendar days of the med being expired, discontinued, or there being notification of recall. Medication, including patches, have specific rules for disposal as they can be incredibly dangerous if not disposed of properly. ***Medications prescribed to a resident that has died MUST be properly disposed of.** If in doubt on how to properly dispose of medications, you can contact the pharmacy you received the medication from or look up information regarding the Medication Take Back program. This information can be found here: https://medtakebackoregon.org/

If you have any questions, email the policy team at: APD.AFHTeam@odhsoha.oregon.gov