# Adult Foster Home Provider Alert

**Policy updates, rule clarifications and announcements**

**Date:** January 24, 2023

**To:** APD Adult Foster Home Providers

**From:** Safety, Oversight and Quality Unit

**Topic:** **Frequently Cited Violations Report - Fourth Quarter 2022**

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. There are five that are a repeat from the previous quarter in 2022 and five that are new to this report.

**Report dates: October 1, 2022 – December 31, 2022**

## HOME AND RECORDS VIOLATIONS

**Violation: Health Professional Orders: Implements Order** (411-051-0130(4))
HEALTH CARE PROFESSIONAL ORDERS (IMPLEMENTED BY AFH STAFF). The licensee or administrator who implements a hospice, home health, or other licensed medical professional-generated order must:
(a) Have a copy of the hospice, home health, or licensed medical professional document that communicates the written order. (b) Transcribe the order onto the medication administration record (MAR). (c) Implement the order as written. (d) Include the order on subsequent medical visit reports for the prescribing practitioner to review.

**Corrective Action:** When a new order has been received the AFH staff are responsible for ensuring the order is given as directed by the prescriber. This

can include orders related to medications, skin care, or other treatment or diet orders.

**Violation: Resident Records: Narratives** 411-050-0750(2) Resident Records (j) NARRATIVE OF RESIDENT'S PROGRESS. Narrative entries describing each resident's progress must be documented at least weekly and maintained in each resident's individual record. All entries must be signed and dated by the person writing them.

**Corrective Action:** There must be written updates related to resident progress that are maintained at least weekly. These notes help to give insight into the resident's adjustment in the home and can be useful in determining changes of condition or overall resident wellness.

**Violation: Sub CG Req: CPR & FA** 411-049-0125 (9)(g) Caregiver Qualifications (9) SUBSTITUTE CAREGIVER REQUIREMENTS. A substitute caregiver left in charge of the residents for any period of time, may not be a resident, and must at a minimum, meet all the following qualifications prior to working alone in the home. (g) Substitute caregivers must complete CPR and First Aid training and certification within 30 calendar days of the start of employment. Certification must be maintained according to the standards established in (2)(b)(D) of this rule.

**Corrective Action:** Substitute caregivers must complete both approved CPR and First Aid training within 30 days of having been hired. These records must be kept on file in the AFH and be made available to licensing upon request.

**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 (repeat from previous quarter)** **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 before or after giving a medication to a resident, as it increases the likelihood of medication mistakes being made. Furthermore, documenting those medications have been given at any time other than when the medication is actually given is falsification of records.

**Violation: MARs: PRN Medication:** 411-051-0130 (7) Standards for Medications, Treatments and Therapies Documentation (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.
(a) PRN DOCUMENTATION. As needed medications must be documented on the resident's MAR with the time, dose, the reason the medication was given, and the outcome.

**Corrective Action:** When a PRN medication has been given to a resident it must be charted properly on the MAR. This process includes noting several details.

- The **time** the medication was given (so other caregivers know when another dose may be allowed, if needed).
- The **dosage** must also be noted because there could be limitations on how many doses could be offered in a 24-hour timeframe.
- The **reason** for the medication should be noted – what was the resident complaint?
- And lastly, the **outcome** should– was the pain or discomfort minimized or is the resident still noting concerns?

**Violation: MARs: List & Identify Treatments (repeat from previous quarter)** **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.

**Corrective Action:** A medication administration record (MAR) is to be kept for all residents.

**Violation:** **MARs: PRN Medication: Parameters (repeat from previous quarter)** **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.

**Corrective Action:** 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.

**Violation:** **Medication Supplies (repeat from previous quarter)** **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 (repeat from previous quarter)** **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: Medication: Changed Orders** 411-051-0130 (2)(a) Standards for Medications, Treatments and Therapies CHANGED ORDERS. (a) Changes to a written order may not be made without a prescribing practitioner order. The prescribing practitioner must be notified if the resident refuses to consent to the change order. Changes to medical orders obtained by telephone must be followed-up with signed orders within seven calendar days. Changes in the dosage or frequency of an existing medication require a new properly labeled and dispensed medication container. If a new properly labeled and dispensed medication container is not obtained, the change must be written on an auxiliary label attached to the medication container, not to deface the existing original pharmacy label, and must match the new medication order. Attachment of the auxiliary label must be documented in the residents' record. (See section (6)(d) of this rule).

**Corrective Action:** Changes to medication orders must be prescribed and the changes must be noted on the MAR and be clearly labeled so all caregivers know the appropriate dose to offer on medications.

If you have any questions, email APD.AFHTeam@odhs.oregon.gov