Adult Foster Home Provider Alert

Policy updates, rule clarifications and announcements

Date: January 19, 2024

To: APD Adult Foster Home Providers

From: Safety, Oversight and Quality Unit

Topic: **Frequently Cited Violations Report – Third Quarter 2023**

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 intended 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. This quarter, there were three violations that were cited frequently in the previous quarter as well. There are seven new violations of rule noted with a focus on medication and MAR errors.

Report dates: July 1, 2023 to September 30, 2023

HOME AND RECORDS VIOLATIONS

Violation: Background Check 411-049-0120(1)(a) (repeat from last quarter)
(1) All subject individuals (SI) must have an approved background check, which for non-licensees or non-licensee applicants, may include an approved preliminary fitness determination, prior to operating, working in, training in, or living in an AFH.

(a) Licensees must maintain documentation of preliminary and final fitness determinations with the home's facility records in accordance with these rules and the background check rules.

APD means Aging and People with Physical Disabilities. APD adult foster homes are licensed to care for adults who are older and adults with physical disabilities.

Corrective Action: Licensee must ensure all subject individuals have approved background checks and the approval records should be kept with the facility caregiver records.

Violation: Resident Records: Narratives 411-050-0750(2) (repeat from last quarter)

(2) The record must contain the following information:

(k) 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: Safety: Evacuation Drill 411-050-0725(3)(a) (repeat from last quarter)

(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.

(a) The evacuation drill must be clearly documented, signed by the caregiver conducting the drill, and maintained according to OAR 411-050-0745(1)(g).

Corrective Action: Evacuations drills are required to be held at least every 90 calendar days and at least one drill must be conducted during sleeping hours. A form indicating completion of this requirement must be kept in the facility records.

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 last 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: Parameters (repeat from last 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 last 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 last 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: Details 411-051-0130 (6)(a) Standards for Medications, Treatments and (a) List the name of all medications administered by a caregiver, including over-the-counter medications and prescribed dietary supplements. The MAR must identify the dosage, route, date, and time each medication and supplement is to be given.

Corrective Action: The MAR must include the names of all medications, including those that are over the counter, as well as all dietary supplements. All details should be noted on the MAR including the dosage, route, date, and time for each medication dose to be given.

Violation: 411-051-0130 Standards for Medications, Treatments, and Therapies (6)(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: The MAR must include all treatments and therapies offered by caregivers and note the time each treatment or therapy is to be offered.

Violation: 411-050-0750 Resident Records: An individual resident record must be developed, kept current, and readily accessible on the premises of the home for each individual admitted to the AFH. The record must be legible and kept in an organized manner so as to be utilized by staff:

(2)(f)(E): Copies of Guardianship, Conservatorship, Advance Directive for Health Care, Power of Attorney, and Physician's Order for Life Sustaining Treatment (POLST) documents, as applicable.

Corrective Action: Resident records must include legible copies of the guardianship, conservatorship, POA, or POLST, if applicable. NOTE: not all residents will have these documents but, when they do, it is critical they be kept in a place that is accessible and known to all caregiving staff.

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