Adult Foster Home Provider Alert

Policy updates, rule clarifications and announcements

Date: July 24, 2024

To: APD Adult Foster Home Providers

From: Safety, Oversight and Quality Unit

Topic: **Frequently Cited Violations – Quarter 1 2024**

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: January 1,2024 to March 31, 2024.

Violation: Care Plan – 14 days OAR 411-051-0115(1)(a-o) During the initial 14 calendar days following the resident's admission to the home, the licensee or administrator must continue to assess and document the resident's preferences and care needs. The assessment and care plan must be completed by the licensee or administrator and documented within the initial 14-day period. The care plan must describe the resident's needs, preferences, capabilities, what assistance the resident requires for various tasks, and must include:

(a) By whom, when, and how often care and services shall be provided.
(b) The resident's ability to perform activities of daily living (ADLs).
(c) Special equipment needs.
(d) Communication needs (examples may include, but are not limited to, hearing or vision needs, such as eraser boards or flash cards, or language barriers, such as sign language or non-English speaking).
(e) Night needs.

(f) Medical or physical health problems, including physical disabilities, relevant to care and services.
(g) Cognitive, emotional, or other impairments relevant to care and services.
(h) Treatments, procedures, or therapies.
(i) Registered nurse consultation, teaching, delegation, or assessment.
(j) Behavioral interventions.
(k) Social, spiritual, and emotional needs, including lifestyle preferences, activities, and significant others involved. (k) Social, spiritual, and emotional needs, including lifestyle preferences, activities, and significant others involved.
(l) The ability to exit in an emergency, including assistance and equipment needed.
(m) Any use of physical restraints or psychotropic medications.
(n) Dietary needs and preferences.
(o) Any individually-based limitations according to OAR 411-051-0105 (3).

Corrective Action: The initial care planning is critical because it is during this time the licensee or admisnitrator is learning about the resident and making changes to support new knowledge related to resident care and preferences.

Violation: MARs: Details OAR 411-051-0130(6)(a) MEDICATION ADMINISTRATION RECORD. A current, written MAR, or electronic MAR (see OAR 411-050-0755(4)), must be kept for each resident and must: (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: A MAR is to be kept for all residents and must include all medications prescribed for each resident. This includes all PRN (as needed) medications.

Violation: MARs Immediately Initialed OAR 411-051-0130(6)(c) 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: In order to have a safe medication administration system the MAR must be initialed when the medication is being given. This practice significantly lowers the risk of double dosing since there is clear documentation of the medication having been given. There must also be a space that shows caregiver names and initials so it is clear who has given each medication.

Violation: MARs PRN Medication: Documentation OAR 411-051-0130(7)(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 administering a PRN medication there are details that must be noted on the MAR. These include the time the dose was given, the amount, the reason and the outcome. Was the medication able to remedy the resident concern(s)? This documentation helps the other caregivers to know if a follow-up dose is appropriate and can help with communication with the resident’s prescribing doctor if there is a noted trend of a PRN medication not being helpful over time.

Violation: MARs PRN Medication Parameters OAR 411-051-0130(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: All PRN medications must include clear guidelines for caregivers so they know how to administer the presecibed medication safely. What is the dose? How often is it to be given? For what symptoms?

Violation: 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: All medications, including PRN medications, must be kept in the AFH and be available for use. If refills are needed documentation of efforts to get a new supply must be noted in the resident's record.

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: All orders related to resident's care need to be signed and kept in the resident records. All orders must be carried out as prescribed unless the resident refuses.

Violation: Medication Changed Orders OAR 411-051-0130(2)(a) CHANGED ORDERS. 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.

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.

Violation: Medication Supplies/ Disposal OAR 411-051-0130(10)(a) 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: Transdermal patches must be disposed of appropriately as they pose a serious health risk to all AFH occupants when left unsecure or unattended. Patches are to be folded in half sticky side together to prevent accidental exposure to the medication within.

Violation: Psychotropic Medications: Care Plan OAR 411-051-0130(8)(f)
The resident's care plan must identify and describe the behavioral symptoms the psychotropic medications are prescribed for and a list of all interventions, including interventions that are non-pharmacological and medications.

Corrective Action: The care plan must detail the reason for the psychotropic medication and include interventions, including ones that do not involve medication administration.

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