Summary of key points of sections 5, 7, 11 and 12 of the Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs, level 4 residential care facilities

**Section 5- Resident Rights**

 5.14 Residents shall be treated with respect and consideration for privacy when receiving personal care or treatment and preferred mode of language and communication.

 5.20 Residents may choose to refuse medications, treatments or services. If the resident refuses necessary care or treatment, the provider shall make reasonable efforts to consult the resident’s licensed practitioner, caseworker or other appropriate individuals in order to encourage residents to receive necessary services.

**Section 7- Medications and Treatments**

 7.1 Use of safe and acceptable procedures- The administrator shall ensure that all persons administering medications and treatments (except residents who self-administer) use safe and acceptable methods and procedures for ordering, receiving, storing, administering, documentation, packaging, discontinuing, returning for credit and/or destroying of medications and biologicals. All employees must practice proper hand washing and aseptic techniques. A hand washing sink shall be available for staff administering medications.

7.1.1 Residents shall receive only the medications ordered by his/her duly authorized licensed practitioner in the correct dose, at the correct time, and by the correct route of administration consistent with pharmaceutical standards.

7.1.2 No injectable medications may be administered by an unlicensed person, with the exception of bee sting kits and insulin

7.1.3 Before using a bee sting kit, unlicensed persons must be trained by a registered professional nurse in regard to safe and proper use. Documentation of training shall be included in the employee record.

7.1.4 Unlicensed assistive personnel must be trained by a registered professional nurse in regard to the management of persons with diabetes. Review of this training shall be on an annual basis.

The registered professional nurse must provide in-service training and documentation to include:

7.1.4.1 Dietary requirements

7.1.4.2 Anti-Diabetic Oral medications – inclusive of adverse reactions and interventions, hyper and hypoglycemic reactions

7.1.4.3 Insulin mixing including insulin action

7.1.4.4 Insulin storage

7.1.4.5 Injection techniques and site rotation

7.1.4.6 Treatment and prevention of insulin reaction including signs/symptoms

7.1.4.7 Foot care

7.1.4.8 Lab testing, urine testing and blood glucose monitoring; and

7.1.4.9 Standard Precautions- Documentation of training shall be included in the employee record 7.1.5 Urine testing shall not be done around medication or areas where food is stored or prepared. Proper Standard Precautions relative to body fluids shall be implemented

7.1.6 No medications, including those brought into the facility by the resident, family or friends, shall be administered or discontinued without a written order signed by a licensed prescriber

7.1.7 Orders for medications and treatments shall be in writing, signed and dated by a licensed practitioner and shall be in effect for the time specified by the licensed practitioner, but in no case to exceed twelve (12) months, unless there is a written reorder. **Orders for psychotropic medications shall be reissued every three (3) months, unless otherwise indicated by the duly authorized licensed practitioner.** Standing orders for individual residents are acceptable when signed and dated by the duly authorized licensed practitioner.

7.1.7.1 Upon admission to another facility, all existing orders are no longer in effect. Upon return to the facility, all orders must be reviewed and approved by the resident’s duly authorized licensed practitioner within 72 hours. During that time frame, orders that are signed and dated by the discharging duly authorized licensed practitioner are the current acceptable orders. Prior to admission to another facility all medications must be removed from service and placed in a locked area in accordance with Section 7.7.

7.2 Administration of medications

7.2.1 Self-administration- Upon admission, each individual’s ability to self-administer medications will be determined by an assessment of his/her ability or need for assistance, unless the resident/legal representative elects (in writing) to have the facility administer his/her medications. A final decision will be reached between the resident, his/her legal representative, his/her duly authorized licensed practitioner and a facility representative.

7.2.2 Medications administered by facility- For those medications and/or associated treatments for which the facility is responsible, the following apply:

7.2.2.1 Telephone orders shall be accepted only by a registered or licensed nurse or pharmacist. Written dated orders for telephone orders must be signed by the duly authorized licensed practitioner within five (5) working days.

7.2.2.2 Faxed or written orders are acceptable legal orders for a CRMA as long as they are in compliance with the Commission on Pharmacy regulations.

7.2.3 Unlicensed assistive personnel- Unlicensed assistive personnel administering medications and/or treatments must successfully complete training approved by the Department. There shall be evidence available in the facility that such training has been successfully completed. Whenever the standards or guidelines of the medication administration course are substantially revised, unlicensed personnel must be re-certified within one (1) year of the revision, by a method approved by the Department. An additional exception will be made on a case-by-case basis for persons who only administer dietary supplements and/or minor medicated treatments, shampoos, lotions and creams that could be obtained over the counter without a physician’s order.

A person qualified to administer medications must be on site at the facility whenever a resident(s) have medications prescribed “as needed” (PRN) if this medication is not self-administered.

All unlicensed assistive personnel administering medications and/or treatments must complete a Department-approved eight (8) hour refresher course biennially for re-certification within two (2) years of the original certification.

7.2.4.1 PRN Psychotropic medications- Psychotropic medications ordered "as needed" shall not be administered unless the licensed practitioner has provided detailed behavior-specific written instructions, including symptoms that might require use of medication, exact dosage, exact time frames between dosages and the maximum dosage to be given in a twenty-four (24) hour period. Facility staff shall notify the duly authorized licensed practitioner within twenty-four (24) hours when such a medication has been administered, unless otherwise instructed in writing by the licensed practitioner.

7.2.4.2 A person qualified to administer medications must be on site at the assisted living program or residential care facility whenever a resident(s) have medications prescribed “as needed” (PRN) if this medication is not self-administered. In no event, however, shall antipsychotic-type psychotropic medications be prescribed on a PRN basis only, having no routinely scheduled and administered doses.

7.3 Medication storage

7.3.1 Residents who self-administer medications and who handle their own medical regime may keep medications in their own room. To ensure the safety of the other residents, the facility will provide a locked area/container, if necessary.

7.3.2 Medications administered by the assisted living program or residential care facility shall be kept in their original containers in a locked storage cabinet. The cabinet shall be equipped with separate cubicles, plainly labeled, or with other physical separation for the storage of each resident's medications. It shall be locked when not in use and the key carried by the person on duty in charge of medication administration.

7.3.3 Medications/treatments administered by the assisted living program or residential care facility for external use only shall be kept separate from any medications to be taken internally.

7.3.4 Medications administered by the assisted living program or residential care facility, which require refrigeration, shall be kept safely stored and separate from food by placement in a special tray or container, except vaccines, which must be stored in a separate refrigeration unit that is not used to store food. Refrigeration shall not exceed forty-one (41) degrees Fahrenheit. A thermometer shall be used to ensure proper refrigeration.

7.4 Temporary absences- When a temporary absence from the facility is expected to be greater than seventy-two (72) hours, medications leaving the facility (except those by residents who self-administer) must be in a form packaged and labeled by a pharmacist. For medications leaving the facility for seventy-two (72) hours or less, the medication shall be packaged in such a way as to facilitate self-administration or administration by a responsible party of the correct medication at the appropriate time. Properly certified or licensed staff will use acceptable methods and procedures for preparing medications for leaving the facility. Staff will follow the same policies used in the facility for administering medications. The name of the resident and the name and strength of each drug, as well as the directions from the original prescription package, should be conveyed to the resident or their responsible party along with all cautionary information in writing, either directly on an envelope containing the appropriate dose or on a separate instruction sheet. If the medication is sent in original container, pills must be counted and documented upon leaving and returning to the facility.

 7.5 Medication labeling- Each prescription dispensed by a pharmacy shall be clearly labeled in compliance with requirements of the Commission on Pharmacy and shall include at least the following:

7.5.1 Prescription number

7.5.2 Resident's full name

7.5.3 Name, strength and dosage of the drug

7.5.4 Directions for use

7.5.5 Name of prescribing duly authorized licensed practitioner

7.5.6 Name and address of issuing pharmacy

7.5.7 Date of issue of latest refill

7.5.8 Expiration date

7.6 Improperly labeled medications- For medications administered by the assisted living program or residential care facility, all pharmaceutical containers having soiled, damaged, incomplete, incorrect, illegible or makeshift labels shall be returned to the original dispensing pharmacy for relabeling within two (2) working days or shall be disposed of in accordance with the requirements contained in Section 7.9.

7.7 Expired and discontinued medications- For medications administered by the assisted living program or residential care facility, medications shall be removed from use and properly destroyed after the expiration date and when discontinued, according to procedures contained in Section 7.9. They shall be taken out of service and locked separately from other medications until reordered or destroyed.

7.8 Medication owned by residents- Prescribed medicines are the property of the resident and shall not be given to or taken by other residents or any other person.

7.9 Destroying medications- For medications administered by the assisted living program or residential care facility, all discontinued medications, expired medications or medications prescribed for a deceased resident, except controlled substances and individual doses, shall be destroyed by the administrator or the administrator’s designee and witnessed by one (1) competent person who is not a resident. The destruction shall be conducted so that no person can use, administer, sell or give away the medication. Individual unit doses may be returned to the pharmacist and a credit or rebate made to the person(s) who originally paid for the medication. Amounts destroyed or returned shall be recorded on the resident's record, with the signature of the administrator or the administrator’s designee and witness(es). Destruction or return to the pharmacy shall take place within sixty (60) calendar days of expiration or discontinuation of a medication or following the death of the resident.

7.10 Schedule II controlled substances- Schedule II controlled substances listed in the Comprehensive Drug Abuse Act of 1970, Public Law 91-513, Section 202 and as amended pursuant to Section 202 are subject to the following standards:

7.10.1 For all Schedule II controlled substances, there shall be an individual record in which shall be recorded the name of the resident, prescription number, the date, drug name, dosage, frequency and method of administration, the signature of the person administering it and verification of the balance on hand.

7.10.2 There shall be a recorded and signed count of all Schedule II controlled substances at least once a day, if such substances have been used in the facility that day.

7.10.3 All Schedule II controlled substances on hand shall be counted at least weekly and records kept of the inventory in a bound book with numbered pages, from which no pages shall be removed.

7.10.4 All Schedule II controlled substances shall be stored under double lock in a separate locked box or cabinet within the medication cabinet or in an approved double-locked cabinet attached to the wall.

7.10.5 All excess and undesired Schedule II controlled substances in the possession of a licensed facility that are no longer required for a resident, shall be disposed of in the following manner. The Administrator or a licensed or registered nurse shall list all such unused substances and keep the same in a securely locked area apart from all other drugs. Disposal shall be in the form of incineration or flushing into the sewage system only in the presence of an authorized representative of the Department, a licensed pharmacist, a member of the Commission on Pharmacy or an authorized representative of the Drug Enforcement Agency. At least one (1) of the persons must be a person who did not dispense the drug or who was the last person to inventory the drug. Documentation of such destruction shall be made on the resident's record and in the inventory record required in Section 7.10.3, signed by the individual authorized to dispose of the drug.

7.11 Bulk supplies- Facilities may stock in bulk supply those items regularly available without prescription at a pharmacy.

7.12 (MAR) Medication/treatment administration records for medications administered by the assisted living program or residential care facility

7.12.1 Individual medication/treatment administration records shall be maintained for each resident and shall include all treatments and medications ordered by the duly authorized licensed practitioner. The name of the medication, dosage, route and time to be given shall be recorded in the medication/treatment administration record. Documentation of treatments ordered and time to be done shall be maintained in the same manner. These rules apply only to treatments ordered by licensed health care professionals

7.12.2 Whenever a medication or treatment is started, given, refused or discontinued, including those ordered to be administered as needed (PRN), the medication or treatment shall be documented on the MAR. It shall be initialed by the administering individual, with the full signature of the individual written on the first page of each month’s MAR. A medication or treatment shall not be discontinued without evidence of a stop order signed and dated by the duly authorized licensed practitioner.

7.12.3 Medication errors and reactions shall be recorded in an incident report in the resident's record. Medication errors include errors of omission, as well as errors of commission. Errors in documentation or charting are errors of omission

7.12.4 Administration of medications ordered as needed (PRN) shall be documented and shall include date, time given, medication and dosage, route, reason given, results or response and initials or signature of administering individual. Treatments ordered PRN shall be documented in the same manner.

7.13 Medication containers. Graduated medicine containers, for the accurate measurement of liquid medications, shall be used. If not disposable, medicine containers shall be returned to the facility's dishwashing unit for sanitization after each use. Only sterile disposable syringes and needles shall be used for insulin injection. Disposable medicine containers shall not be reused.

7.14 Breathing apparatus. When the facility assists a resident with a hand-held bronchodilator, metered dose nebulizers, intermittent positive pressure breathing machine or oxygen machine, there shall be documentation of the following:

7.14.1 The names of staff who are qualified or trained to use the equipment and/or to mix medications, the nature of their training, the date and who provided it;

7.14.2 The name of the distributing agency and the frequency and specific directions for cleaning the equipment; and

7.14.3 The resident’s record shall contain a copy of the duly authorized licensed practitioner’s order, possible side effects to be monitored, specific instructions as to when the duly authorized licensed practitioner must be notified regarding side effects and instructions to the resident on the use of the breathing apparatus.

7.15 First aid kit. A first aid kit containing supplies which may be necessary for the first aid treatment of minor injuries such as cuts, scrapes or first degree burns shall be included and available in the facility. All staff shall be instructed in the use of any item in the kit.

7.16 Whenever a Registered Nurse teaches or provides in-service training to unlicensed personnel on medical issues, treatments and/or medical equipment not specifically outlined in these Regulations, there must be documentation in the employee file.

7.17 Whenever employees are provided in service training or are taught procedures, the use of equipment or anything else which impacts resident care, there must be documentation in the employee file. This in service training could be taught by other professionals including a Physician, Registered Nurse, Practitioner, Dietician, Physical Therapist, Occupation Therapist, Speech Therapist, product company representative, or other experts in their field.

**Section 11- Administrative and resident records**

11.1 Individual records must include:

11.1.4 Written and dated orders signed by a licensed practitioner for all treatments and medications 11.1.5 Individual medication records, kept in accordance with Section 7.12 of these regulations 11.1.6.4 Visits to or by the licensed practitioner or other health professional

11.1.7 Incident reports- An incident report shall be completed for any resident who has a medication reaction, or when an error is made in the documentation or administration of medication. The report shall describe the incident and indicate the extent of the injury or reaction and necessary treatment. The dispensing pharmacy shall be consulted regarding incidents involving medications, in order to assist in assessing adverse drug reaction, drug-drug interaction, drug-food interaction and allergies/sensitivities. If, in the opinion of the administrator or person in charge, the incident is not serious enough to call an examining duly authorized licensed practitioner, an incident report shall still be recorded in the resident's record. The administrator shall initial the record within seventy-two (72) hours. If examination and treatment by a duly authorized licensed practitioner is necessary as a result of an incident, the facility shall notify the guardian or conservator as soon as possible, within seventy-two (72) hours.

11.1.8 Refusal of care or treatment. The resident’s record shall contain documentation when a resident refuses to consent to care or treatment which the facility is required to provide in accordance with the standards for resident care (Section 12) or as prescribed by a duly authorized licensed practitioner.

11.1.9 Referral/transfer form. A referral or transfer form shall be prepared when any resident is transferred from one facility to another facility, with a copy of the resident's record at both facilities to include a copy of the resident’s most recent medication orders

**Section 12- Standards of care**

12.14 Refusal of care or treatment**.** In the event that a resident refuses necessary care or treatment, the facility shall document reasonable efforts made to consult with the resident’s licensed medical professional, the registered nurse consultant, caseworker or other appropriate individuals in order to ensure that residents receive necessary services. However, in no case shall a person who does not have legal authority to do so, order treatment that has not been consented to by a competent resident.