

Medication Oversight in Assisted Living

Practical Strategies to Prevent Citations



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Session Objectives



Top-Cited Medication Deficiencies

- *Review frequently cited tags*
- *Understand what each tag covers*



Discuss Real-World Examples

- *Examples of cited deficiencies*



Practical Strategies to Improve Oversight

- *Implement a daily check for medication exceptions*
- *Preview elements of a strong audit tool*
- *Incorporate Audit findings in QMP/QAPI Meetings*



Survey Readiness

- *Create systems that reduce last-minute scrambling before surveys.*
- *Promote a culture of consistent documentation and accountability.*

Tag #1568 - Compliance with Practitioner's Orders

Regulatory Reference: 14.21 – *The assisted living residence shall be responsible for complying with authorized practitioner orders associated with medication administration, except for those medications which a resident self-administers.*

Common Citation Examples:

- Meds given without a current signed practitioner order
- Medication ordered, but not available to administer
- Dose or route changed without an updated order on hand to review
- Meds held or discontinued without an order on hand to review
- Missing orders at admission / readmission
- Expired or unavailable PRN medications

Tag #1600 - Accuracy of Medication Administration Record (MAR)

Regulatory Reference: 14.29 – All prescribed and PRN medications shall be listed and recorded on a Medication Administration Record (MAR), which must include:

- Resident name, DOB, room, allergies, and authorized practitioner contact
- Name, strength, dosage, route, date/time of administration, special considerations, initials/signature
- A legible list of staff using the MAR with their initials/signatures
- Timely documentation of each administration or monitoring event
- Accurate record of omissions, refusals, and responses

Common Citation Examples:

- Blank spots or missing initials on the MAR (“holes”)
- Transcription errors (wrong medication, dosage, or frequency)
- Missing documentation for PRNs or effectiveness follow-up
- MAR not updated for discontinued/held meds
- Illegible initials or missing MAR user signature log

Tag #1604 – Quarterly Medication Audits

Regulatory Reference: 14.31 – *The administrator and the QMAP supervisor shall, on a quarterly basis, audit the accuracy and completeness of the medication administration records, controlled substance list, medication error reports, and medication disposal records. Any irregularities shall be investigated and resolved. The results of the audits shall be documented and routinely included as part of the assisted living residence's Quality Management Program assessment and review.*

Common Citation Examples:

- Quarterly audit not completed or not documented
- No investigation or follow-up on identified errors or discrepancies
- Controlled substance count not reconciled against MAR or shift logs
- Disposal records are incomplete or missing witness signatures
- No evidence of audit findings included in QAPI/Quality Management Program meetings

Tag #1110 – Protective Oversight / Minimum Services

Regulatory Reference: 12.1 – *The assisted living residence shall make available, either directly or indirectly through a resident agreement, the following services, sufficient to meet the needs of the residents:*

(C) Personal services including, but not limited to, a system for identifying and reporting resident concerns that require either an immediate individualized approach or ongoing monitoring and possible re-assessment;

(D) Protective oversight including, but not limited to, taking appropriate measures when confronted with an unanticipated situation or event involving one or more residents and the identification of urgent issues or concerns that require an immediate individualized approach.

Common Citation Examples:

- Resident using oxygen without a signed practitioner order or without specific personal services documented in the Care Plan (e.g., liters of O₂, staff assistance)
- No documented crush order when meds are being crushed, or meds not crushed when an order exists
- Resident using TED hose or compression stockings with a valid order, but no staff assistance listed in the Care Plan

Name That Tag...



Scenario 1:

A QMAP administers the resident's Levothyroxine each morning but forgets to initial the MAR on two separate days. During an audit, it appears the medication was not signed off as administered. When questioned, the QMAP says, "I gave it - I just forgot to sign."

Regulatory Focus:

The MAR must contain all required information and be completed accurately and timely.

Tag #1600 – Medication Administration Record (MAR) Accuracy (14.29)

Name That Tag...



Scenario 2:

The community's Wellness Director completes the quarterly medication audit alone. She reviews MARs and addresses documentation issues, such as missed initials and expired PRNs. The audit is reviewed at the community's Quality Management Program meeting.

Regulatory Focus:

Quarterly audits must assess the accuracy of MARs, error reports, controlled substances, and disposal logs, with documented findings and follow-up.

Tag #1604 – Quarterly Medication Audit (14.31)

Name That Tag...



Scenario 3:

A resident who is prescribed 2L of oxygen via nasal cannula is observed without oxygen during a survey. When asked, staff state, “the resident doesn’t like to wear it and hasn’t worn it for months.” There was no documentation in the progress notes or care plan reflecting this choice, nor any evidence that the PCP was notified or that discontinuation of the order was attempted.

Regulatory Focus:

ALRs must provide oversight to prevent harm, including ensuring care aligns with individualized needs and orders.

**Tag #1110 – Protective Oversight /
Minimum Services (12.1)**

Name That Tag...



Scenario 4:

A resident has an order to wear TED hose, but no information about Ted hose is documented in the care plan. Staff are unaware they're expected to apply the TED hose, and the resident is unable to put the TED hose on independently.

**Tag #1110 – Protective Oversight /
Minimum Services (12.1)**

Name That Tag...



Scenario 5:

A resident is readmitted from the hospital with a discharge summary listing several medications, including a new blood pressure medication. The nurse transcribes the list into the MAR, but no formal practitioner order is received or scanned into the chart. QMAPs administer the medication for over a week before anyone notices that the signed order is missing.

Regulatory Focus:

Medications must be administered in accordance with valid, current practitioner orders.

**Tag #1568 – Compliance with
Practitioner Orders (14.21)**

Name That Tag...



Scenario 6:

A medication appears on the MAR with an incorrect dose (e.g., 25mg instead of 50mg) due to a transcription error from the practitioner's order.

Tag #1600 – Medication Administration Record (MAR) Accuracy (14.29)

Name That Tag...



Scenario 7:

The community's Administrator and QMAP Supervisor perform quarterly audits but only check whether all MARs have initials - no review of controlled substance counts or disposal records is done. The audit documentation only states "reviewed no concerns."

Tag #1604 – Quarterly Medication Audit (14.31)

Name That Tag...



Scenario 8:

During an afternoon med pass, the agency QMAP did not crush medications for a resident with a documented crush order. The resident was later observed with a whole pill on the front of their shirt. Staff reported they thought the med had been taken.

**Tag #1110 – Protective Oversight /
Minimum Services (12.1)**

Name That Tag...



Scenario 9:

During a routine evening medication pass, a QMAP is approached by a hospice RN who is visiting a resident receiving end-of-life care. The resident has been experiencing significant pain, and the hospice nurse instructs the QMAP to give another dose of the resident's regularly scheduled pain medication, stating, "Go ahead and give an extra dose now to help keep them comfortable." The QMAP checks the MAR and the electronic record but does not find a signed order from the prescribing practitioner authorizing this additional dose. Despite this, the QMAP administers the extra dose based solely on the hospice nurse's verbal direction.

**Tag #1568 – Compliance with
Practitioner Orders (14.21)**

How many of you run daily reports or check for...



- Missed Meds (Holes in MAR)
- Medications Not Available
- Held Meds
- Pattern of Requested PRNs or Medication Refusals (*Tag #1612 - Regulation 14.33*)

Even a quick daily check can prevent citations

Practical Strategies to Improve Oversight

Implement a daily touchpoint to review systems for medication issues:

- Missed Meds
- Medications Not Available
- Held Meds
- Requested PRNs / Refused Meds
- Documentation Discrepancies or Medication Errors

Build it into a shift-change or daily wellness huddle

Audit Strategy Preview

Key elements of a strong **Quarterly Med Audit Tool** include:

- MAR vs. Orders vs. Meds In Cart / Available
- Review Med Errors, Controlled Substance Logs, Medication Disposal Records

Colorado Quarterly Medication Audit

Community Name: _____ Date: _____

Quarter Audited: ☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4 Year: _____

Auditor Names / Titles (print): _____

Colorado regulations 6 CCR 1011-1 Chapter 7 Section 14.31– Assisted Living Residences requires Communities to conduct quarterly medication audits as part of the Quality Management Program. By signing below, you are confirming that you have reviewed the ***Accuracy and Completeness of the Medication Administration Records (MARs), Controlled Substance List, Medication Error Reports/Internal Incident Reports***, and the ***Medication Disposal Record***. Any discrepancy in the list and count of medications designated for disposal shall be immediately reported to the Executive Director/Administrator. *Audit records are maintained for a minimum of 3 years.*

Documents Reviewed			
MAR	Controlled Substances	Med Error Incident Occurrence Reports	Medication Disposal Record
☐	☐	☐	☐

Discrepancies Found (If none found, write “None”)

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Executive Director / Administrator Signature	QMAP Supervisor Signature	Date

Resident Name / Apt #	Date of Most Recent Signed Physician Order Sheet (POS)	MARS have corresponding Signed Orders	MARS match Meds in Cart (Bottles / Cards)	All Meds including PRN's available and not expired	Comments / Discrepancies

From Audit to Action

Track and follow through on audit findings:

- Document trends and irregularities
- Assign follow-up responsibility
- Review in QMP / QAPI meetings
- Log trainings, corrective actions, and resolutions

Use findings to drive education and accountability.

Other Oversight Tactics

- Daily/Weekly/Monthly Audits and MAR spot checks
- Routine observation of med passes
- Validate Med Orders after Hospitalizations / Readmissions

*Create a Culture Where Oversight =
Quality, Not Punishment*

Survey Readiness...

Stop the Scramble

Create systems that prepare you daily:

- Med exception reports and follow-up
- Using real-time data for compliance tracking and share improvements

Don't wait for CDPHE surveyors to arrive to check compliance.

Culture of Documentation

Promote consistency:

- Timely and accurate med documentation
- Reinforce the “Why” behind every MAR entry
- Include the “What”, including PCP, POA, Pharmacy notification, follow-up, and status of medication that is unavailable.
- Include documentation standards in orientation and retrain often

Set early expectations and model compliance.

Build Better Systems

Use oversight to strengthen your framework:

- Tie QMP/QAPI goals to Med Management
- Train on Common Citation tags (e.g., #1568, #1600, #1604, #1110)
- Integrate audit results into staff education and improve QMAP Competencies

Survey readiness is an outcome of strong systems.

Elevate Care, Not Just Compliance

- **Compliance Protects Residents**

Regulations exist to ensure safety, dignity, and well-being.

- **Documentation Tells the Story**

If it isn't documented, it didn't happen- make every action count.

- **Oversight Builds Culture**

Regular review and accountability shape team habits and expectations.

- **Audits Don't Just Fix - They Prevent from Reoccurring**

Effective audit systems catch gaps before surveyors do.

*And most importantly, ensure better care
and outcomes for your residents.*

Questions?

Thank You!

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