| **Subcontracted Provider Name:** | | **Region:** |
| --- | --- | --- |
| **Agency Address:** | | |
| **Agency Contact Person:** | **Title:** | |
| **Contact Email:** | **Contact Phone Number:** | |

|  |  |
| --- | --- |
| **Reporting Period:** | **(select date) to (select date)** |

|  |  |
| --- | --- |
| **Number of Programs where Unlicensed Persons Administer Medications:** | |
| **507** |  |
| **518** |  |
| **521** |  |
| **524** |  |
| **525** |  |
| **1001** |  |
| **507/1001 Combo** |  |
| **521/1001 Combo** |  |
| **525/1001 Combo** |  |

|  |  |
| --- | --- |
| **Number of Current Authorized Providers** |  |
| **Number of Individuals Receiving Medications From Authorized Providers** |  |
| **Number of Medically Frail Individuals** |  |
| **Number of Medication Errors that Resulted in Medical Treatment (for DD individuals only)** |  |
| **Number of Medication Errors that Resulted in Medical Treatment (for ABD individuals only )** |  |
| **Number of Individuals on ≥ 4 Psychotropic Medications**  ***(For those on ≥4 psychotropic medications, please consider psychiatric provider involvement.)*** |  |

|  |  |
| --- | --- |
| Medication Errors Occurrences for this Provider Agency | |
| **Wrong Medication** |  |
| **Wrong Time** |  |
| **Wrong Dose** |  |
| **Wrong Person** |  |
| **Wrong Route** |  |
| **Omission of Medication** |  |
| **Documentation Error** |  |

|  |  |
| --- | --- |
| **Summary of Medication Errors** | |
| **Total Number of Errors** |  |
| **Total Number of Prescribed Doses** |  |
| **Error to Dosage Ratio** |  |

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| --- |
| **Summary of Significant Changes in Individual’s Health Status and Associated Actions Taken** |
|  |

| **Provider Agency Name:** | **Region:** |
| --- | --- |

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| --- |
| **Areas of Increased Compliance and/or Positive Trends** |
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| **Patterns of Non-Compliance and/or Identified Trends; Please Include Corrective Action Taken by the Provider Agency** |
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| --- |
| **Provider Agency’s Plan of Monitoring, Oversight and Quality Improvement Initiatives** |
|  |

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| --- |
| **Areas of Concern and/or Additional Information** |
|  |

|  |  |
| --- | --- |
| **Name of Provider Director or Designee\*:** | **Date:** |
| **Signature or Electronic Signature:** | |
| **Contact Phone Number:** | |

*\*must be someone other than a Nurse Trainer*