

**Bureau of Developmental Services: He-M 1201  
Provider Agency Instructions for Completion of Form 1201-B**

This form is required by He-M 1201-Administration of Medications in Developmental Services Programs. It is to be completed by contracted provider agencies and sent to the area agency two times per year pursuant to He-M 1201.11. The intent of the regulations is that it be completed from a programmatic/supervisory position. If an area agency provides their own services, please include those respective 1201 A reports on a B form from the programmatic/supervisory arrangement.

The form is designed to generate summary statements regarding each provider agency's or area agency entity's oversight of healthcare coordination and safe medication administration. The information entered onto the form will be generated through compilation of all the Form 1201-A's submitted by the Nurse Trainer.

Please read the following instructions carefully before filling out the form and please complete all items. **Indicate "0", "none" or "N/A" when applicable. Do not leave any sections blank.**

**Region:** Please circle or otherwise indicate the Region at the top of the form.

1. **Provider Agency Name:** Enter the name of the provider agency.
2. **Certification Type:** Check the corresponding box for the type of certified service: Please use separate B forms for certified residential and day programs. If programs **are already** combined programs in a certified home (e.g. there are three res/day combination programs; and five 1001 homes with a 525 bed), please include these as 1001 residential.
  - He-M 1001 (Residential services)
  - He-M 507 (Day services)
  - He-M 521 (Home with personal care services for an adult family member)
  - He-M 524 (Home with personal care services for family member under 21)
  - He-M 525 (Participant-directed and managed services)
3. **Report Period Dates:** Enter the dates for the reporting period pursuant to He-M 1201.
4. **Total number of doses administered:** enter the total number of doses administered within each provider agency by adding the total doses administered for all 1201-A Forms.
5. **Total number of providers authorized:** Indicate the number of providers who are presently authorized to administer medications within each provider agency.
6. **Number of psychotropic medications prescribed:** Indicate how many psychotropic medication were prescribed for individuals living in the residences during the reporting period, including PRNs.
7. **Number of individuals identified to be in frail health.** Enter the number of individuals living who are receiving certified services and considered to be in frail health.
8. **Number of medication errors that resulted in medical treatment:** An error that may have contributed to or resulted in temporary harm to the individual and required intervention.

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<b>Summary of Number and Type of Medication Occurrences for this Provider Agency</b>
Total the number by type of medication administration errors by utilizing the data provided on the 1201-A forms.
<b>Significant Changes to Individuals' Health Status and Actions Taken</b>
Please describe significant health changes individuals have experienced and actions taken by the provider agency to ensure individual's health care needs are met.
<b>Identified Trends and Summary of the Providers Agency's Corrective Action Plan</b>
Please read the 1201A Reports to identify any trends in medication administration errors and general trends noted regarding individuals' health status.
<b>Patterns of Non-compliance, if any, and Corrective Action</b>
Please comment on any patterns of non-compliance identified by the Nurse Trainer and include the provider agency's plan of correction.
<b>Provider Agency Plan for Monitoring, Oversight and Quality Improvement</b>
Summarize the provider agency's plan for ensuring that the corrective actions taken by the Nurse Trainer are appropriate and designed to address trends/systemic issues or breaches in medication administration systems such that individuals' risk for future errors is minimized or eliminated. Also summarize the provider agency's plan for healthcare oversight.
<b>Positive Trends or Other Concerns</b>
Please identify any initiatives or proactive measures taken to improve the individual's functional abilities or address any other concerns.