October 27, 2017

Ms. Kerry A. Delaney
Acting Commissioner
Office for People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12229

Dear Ms. Delaney:

The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting people receiving services in facilities under its jurisdiction from abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. To that end, the Justice Center conducts systemic reviews in order to identify risks to the health, safety and welfare of people receiving such services.

On September 7, 2017, the Justice Center issued review findings for [Redacted] DDSOs, entitled Review of Medical Services Provided at [Redacted] DDSOs.1 The final review findings is attached.

This review was conducted by the Justice Center and would not have been possible without the cooperation and professionalism that staff from [Redacted] DDSOs provided during the review. We appreciate and join you in your continuing commitment to the care of vulnerable people in New York State.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

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1This Review was performed pursuant to the Justice Center’s authority as set forth in the Protection of People with Special Needs Act, Chapter 501 of the Laws of 2012.
cc:  Laura Darman, Deputy Executive Director  
     Davin Robinson, Deputy Director, Office of Outreach, Prevention and Support  
     Colleen Carroll-Barbuto, Director, Prevention and Quality Improvement  
     Kari Sovas, Supervising Quality of Care Facility Review Specialist  
     Colleen Slavinski, Quality of Care Facility Review Specialist  
     Tamika Black, OPWDD  
     Michael Feeney, OPWDD  
     Leslie Fuld, OPWDD  
     Michael Savery, OPWDD  
     Brian O'Donnell, OPWDD

NOTE: All correspondence related to this matter will be available for public inspection under Article 6 of the Public Officers Law. Material which will be required to be kept confidential or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to such disclosure.
November 14, 2017

Denise M. Miranda
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, NY  12054

Dear Ms. Miranda,

Thank you for your correspondence dated October 27, 2017, in which you shared a recently completed report regarding the findings of a systemic review conducted by the Justice Center at several group homes operated by the Office for People With Developmental Disabilities (OPWDD). Per your correspondence, the systemic review focused on identification of potential risks to the health, safety and welfare of people receiving services in facilities under the jurisdiction of the Justice Center, and specifically identified some concerns with group homes located in the Developmental Disabilities State Operations Offices. OPWDD has received the report of findings dated September 7, 2017, and is in the process of reviewing the report and determining appropriate corrective actions to be taken.

Thank you again for sharing these important findings with OPWDD. We appreciate your advocacy on behalf of individuals in New York State with developmental disabilities.

Sincerely,

Jill A. Pettinger
Deputy Commissioner
Division of Service Delivery
State Operations and Statewide Services
Justice Center for the Protection of People with Special Needs

Prevention and Quality Improvement Unit

Review of Medical Services Provided at

DDSOs

October 2017
The Justice Center’s Promise to New Yorkers with Special Needs and Disabilities

OUR VISION
People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation’s highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

OUR MISSION
The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

**Integrity:** The Justice Center believes that all people with special needs deserve to be treated with respect and that people’s rights should be protected.

**Quality:** The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

**Accountability:** The Justice Center understands that accountability to the people we serve and the public is paramount.

**Education:** The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

**Collaboration:** Safe-guarding people with special needs is a shared responsibility, and The Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.
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**Contact Information:**

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New York State Justice Center for the Protection of People with Special Needs  
Prevention and Quality Improvement  
161 Delaware Avenue  
Delmar, New York 12054  
(518) 549-1251
Executive Summary

Purpose

This review was initiated in response to a pattern of substantiated cases related to inadequate medical care at state-operated facilities serving people with developmental disabilities. Since July 2013, The Justice Center has substantiated 771 offenses related to inadequate medical care for people receiving services under the auspices of Developmental Disabilities Services Offices (DDSOs). Over twenty percent of the 771 substantiated allegations were found to have seriously endangered the health, safety, and welfare of people receiving services. The Justice Center’s prevention and quality improvement unit (PQI) also received internal referrals concerning the adequacy of medical care from investigators and advocates working with family members of people receiving services through the DDSOs.

The purpose of this review is to identify factors that contribute to inadequate medical care and provide recommendations to promote the health, safety, and welfare of people receiving services. The Justice Center completed six on-site visits at six different state-operated Individual Residential Alternatives (IRAs), examined policies, procedures, clinical records, and spoke with staff working at the IRAs to complete this review.

The Justice Center substantiated 252 offenses related to inadequate medical care at DDSOs between July 2013 and July 2017. Of these substantiations, 57 resulted in a Category 1 or Category 2 finding which means that the offenses seriously endangered the health, safety and welfare of the people receiving services.

<table>
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1 Based on a July 12, 2017 report from the VPCR.
2 Substantiated reports of abuse or neglect are categorized into different categories based on the level of harm or risk of harm to people who receive services. 160 of the allegations were determined to be a Category 1 (serious abuse) or Category 2 (conduct that seriously endangered the health safety or welfare of a person receiving services).
4 Based on a July 12, 2017 report from the VPCR.
5 Based on a July 12, 2017 report from the VPCR.
Program Description

Developmental Disabilities State Operations Offices (DDSOs) administer and oversee state operations for the Office for People With Developmental Disabilities (OPWDD), including the direct delivery of services and supports for people with developmental disabilities in New York State. The residential programs assessed in this review were six different state-operated IRAs. These residential programs serve up to fourteen people and provide 24-hour staff support and supervision, medication administration, and assistance with activities of daily living. Community inclusion, skill development, self-advocacy, community integration, and clinical services are also offered to people who live at IRAs.

Key Findings

- Policies and procedures related to the administration of medication are not consistently followed.
- Medical equipment and medication were not stored properly.
- Systems in place to track medical appointments are ineffective.
- Required staff training is not always provided or adequate.
- Required documentation is often out of date and inaccurate.
- People were required to move when their medical needs changed instead of being afforded the opportunity to age-in-place.

Key Recommendations

- Establish mechanisms to ensure that medication administration policies and procedures are consistently followed.
- Provide oversight to ensure that medical equipment and medications are stored properly.
- Create effective systems to track, organize, and maintain information related to medical appointments, and ensure medical documentation is updated as required.
- Ensure staff receive all required training by implementing a system to effectively monitor training activities and follow-up, to ensure all staff receive training.
- Train staff on documentation requirements, and conduct periodic audits to ensure documentation is accurate, consistent, and that directed interventions are feasible.
- Allow people receiving services to age in place whenever possible.

Review Findings

Background
The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting people in the care of facilities and provider agencies under its jurisdiction against abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. To that end, the Justice Center conducts systemic reviews to identify risks to the health, safety and welfare of people receiving such services.

This review was initiated in response to a pattern of substantiated cases related to inadequate medical care at state-operated facilities serving people with developmental disabilities. PQI also received internal referrals concerning the adequacy of medical care from Justice Center investigators and advocates working with family members of people served by the DDSOs. A review of substantiated allegations in the Justice Center’s database found that inadequate medical care accounted for 17 to 30 percent of all substantiated allegations of abuse and neglect at these three DDSOs, and many were found to have resulted in, or were likely to result in, serious harm to people receiving services. The percentage of substantiated offenses for inadequate medical care of all substantiated offenses, as well as the percentage of inadequate medical care of all offenses found to have seriously endangered people receiving services at these three DDSOs can be found in the table below.6

<table>
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<tr>
<th>DDSO</th>
<th>Inadequate Medical Care as a % of all Substantiated Offenses at the DDSOs 2013-2017</th>
<th>Inadequate Medical Care as a % of all Category 1 or Category 2 Findings at the DDSOs 2013-2017</th>
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**Scope and Methodology**

The Justice Center conducted site visits at:

- DDSO IRA,
- DDSO IRA,
- DDSO IRA,
- DDSO IRA,
- DDSO IRA, and
- DDSO IRA.

The Justice Center chose a sample of 18 people. Some of the people who were selected for review were selected randomly and others were selected based on referrals, or their

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6 Based on a February 22, 2017 report from the VPCR.
prior involvement in abuse or neglect cases. The following documents were requested for each person chosen:

- Medication Administration Records (MARs),
- Resident Profiles,
- Individualized Service Plan (ISP),
- Individualized Plan of Protection (IPOP),
- Behavior Support Plan (BSP),
- Semi-annual/annual meeting packets,
- A list of medical appointments from January 2016 to the time of the site visit,
- Nursing notes from January 2016 to the time of the site visit,
- Consult forms for all medical appointments,
- Documentation from all medical appointments,
- Plans of Nursing Services (PONS), and
- Annual self-medication assessments.

At each of the IRAs visited, the Justice Center reviewed:

- A staff roster,
- Approved Medication Administration Personnel (AMAP) certifications for staff,
- First Aid and cardiopulmonary resuscitation (CPR) training records,
- Medication errors from January 2016 to the time of the site visit,
- Staff assignment sheets for the two weeks prior to the site visit,
- The House Plan of Protection (House POP),
- Minimum staffing ratios, and
- Staff training on when to contact the Registered Nurse (RN).

The Justice Center also requested agency policies on medication errors and when to escalate medical concerns to medical staff or administration.

Findings

The Justice Center’s identified a total of 388 issues at all the six IRAs visited. While examples are provided below, all individual findings are included in the appendix, separated by program.

Medication Administration Policies and Procedures

A. Staff did not follow the required practices related to medication administration.

Medication administration to people receiving services was not consistently documented by staff to indicate that the medication or medical treatment was given to the person receiving services, as required in AMAP training.
In one IRA, a person receiving services was taken to urgent care after reportedly gagging at lunch, and was found to have sores on her mouth, and an elevated temperature. The urgent care physician diagnosed the person with constipation and low potassium, and prescribed potassium. However, the MAR indicated that this person did not receive potassium as prescribed following the visit to urgent care. This was also confirmed by staff during the Justice Center’s site visit. In another IRA, staff did not document medication administration on 12 occasions for one person receiving services in just one month. At another IRA, one person did not receive milk of magnesia, as prescribed in the person’s bowel protocol.7

B. Errors in MARs reflect a failure to comply with the Five Rights of medication administration.

The OPWDD Medication Administration Student Manual states that each time a medication is given, the person administering the medication must ensure the Five Rights have been met. The Five Rights require staff to ensure the person, medication, time, dose, and route are accurate prior to the administration of medication. Since the staff member administering the medication is required to ensure the Five Rights have been met, it is expected that errors in prescriptions or documentation would be identified immediately at each time medication is administered.

A review of MARs from 2017 for the sample selected showed 27 instances where the route of medication was not designated on the MARs. In one case, the MAR documented the incorrect route, guiding staff to administer a medication by mouth, while the person’s written plans explicitly stated that the person was not to receive anything by mouth.8

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7This person’s bowel protocol requires the administration of Milk of Magnesia every three days as needed if no bowel movement.
8 The Justice Center contacted the agency on April 25, 2017, immediately upon discovery.
Example of a MAR with the incorrect route documented, March 2017.

C. Medication documentation errors indicate staff did not comply with the procedures for medication administration and that there is a lack of managerial oversight.

At one IRA, where 14 people resided, 66 medication errors were documented for January 2017, and 26 medication errors were documented for February 2017.

A total of 25 medication errors occurred at another IRA for the time-period reviewed, 20 of which occurred during February 2017 and March 2017. Medication error forms from this IRA were incomplete, not dated, included multiple errors, and were not consistently signed by the person completing the documentation.

D. Required medications were not consistently available.

Site visits and review of the MARs showed 13 instances where required medications were not available at the IRAs. In one IRA, all people receiving services in the sample were each missing two medications that were supposed to be administered on an “as needed” or PRN basis. In another IRA, one person receiving services did not have a prescription for a medication found on her MAR, and the medication was unavailable in the IRA.

The Justice Center also found that policies and procedures concerning the number of medication doses required to be available on site were vague or were not followed. Two of the three DDSOs reviewed required a seven-day supply of all medications. However, at one of the IRAs operated by a DDSO with a seven-day requirement, one person did not have a seven-day supply of medication, which was a controlled substance.
The DDSO that did not have a seven-day requirement for medication supplies, had a procedure that directed staff to ensure that supplies of medications are re-ordered when they are “low.” As a result, people had a very limited supply of medications available. For example, one person only had three doses of a daily medication available. Another person at the same IRA had two daily medications with only four doses available of each medication.

E. MARs did not consistently include allergies, diagnoses, and diet orders.

MAR documentation reviewed was incomplete in all six IRAs reviewed:
- Ten people in the sample did not have their diagnoses listed on their MARs.
- Two people did not have sensitivities to medications listed in the records.
- One person’s IPOP states that she has adverse reactions to a medication, but this is not listed on her MAR.

F. Self-medication assessments were not reviewed annually.

OPWDD requires that agencies conduct annual assessments to determine a person’s capacity to administer their own medications to encourage independence.

One IRA did not provide self-medication assessments for two of the three people in the sample. At another IRA, the agency provided an assessment that was more than three months overdue at the time of the review.

Storage of Medical Equipment and Medication

G. Medical equipment was unhygienic and not stored properly.

Tours of the IRAs revealed issues with the condition, storage, and use of medical equipment. Environmental issues were found at IRAs in two of the DDSO’s reviewed. For example, one IRA had a shower chair they were using for a person receiving services that was covered with a dark, grimy substance. At this same IRA, the screened in porch was being used to store old and non-working pieces of medical equipment, which prevented people living in the house from using this area. At another IRA, a Parker tub located in a bathroom used by people receiving services was covered with a twin mattress pad that smelled of urine. In these IRAs, it appeared that broken, unused, or unhygienic medical equipment remained in the house, without reasonable justification. In another IRA, a G-tube syringe was found in a drawer of an end table in a bedroom.

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9 The Justice Center requested the chair be immediately removed and replaced.
Examples of shower chairs referenced.

Example of common area used to storage unused medical equipment.

I. Medication was not stored properly.

During the tour of one IRA, expired liquid antacid/anti-gas medication was found, as well as PRN medications belonging to a person that no longer lived at the IRA. In another IRA, three containers of Thick-It were found uncovered. In that same IRA, the treatment cabinet was left unlocked and open. Staff on site reported that the cabinet was broken and couldn’t be closed, but the Justice Center was able to close the cabinet.
Medical Appointments

J. Medical appointment documentation was disorganized and incomplete.

The Justice Center requested all documentation related to medical appointments, a list of all medical appointments, and nursing notes for the period of January 1, 2016 to the time of the documentation request for each person receiving services in the sample. Over 40% of the documentation requested by the Justice Center to assess whether follow-up was required after a medical appointment was not provided, even after additional requests were made. The documentation that was provided included many documents were missing pages, illegible, or out of date.

The Justice Center found that 219 of the 850 appointments documented were only recorded in the nursing notes, and additional supporting medical documentation such as consult forms that should have been completed by the agency or appointment documentation that should have been completed by the doctor was not provided.

K. Medical appointments were not adequately tracked to ensure medical appointment follow-up occurred.

The Justice Center found 107 instances where it was documented that a medical appointment was needed, but there was no further evidence that an appointment occurred. This documentation error was found in all six IRAs visited. Examples include:

- A person was scheduled to see his primary doctor following facial surgery after a fall. There was no documentation that any follow-up appointments were scheduled.
- One person went to the dentist in July 2016 and was scheduled for another appointment in November 2016. The Justice Center reviewed documentation in March 2017, but there was no documentation of another dentist visit.

There were 27 appointments that were canceled during the time-period reviewed and one third of these appointments were canceled because the person receiving services either refused to attend or they were having behavioral issues. At one IRA, it was documented in the nursing notes that a staff from the dental office stated that this IRA had excessive appointment cancellations. Additionally, at this same IRA, two people had appointments canceled by the medical provider because the IRA did not have current consent forms.

10 Two people receiving services in the sample moved to the IRA during 2016 and were not living at the home in January 2016.
Follow-up appointments that were documented did not always occur in a timely manner. For example, one person was scheduled to attend an optometry appointment in September, but documentation showed that this person did not see the optometrist until November. In another IRA, a nursing note from May 2016 states that a person’s cardiology appointment was rescheduled to July 2016, although this recommendation to see the cardiologist was made in February 2016.

**Staff Training**

L. Agencies did not maintain staff AMAP certifications and continued to assign untrained staff to administer medication.

Staff assigned to administer medication are required to attend and successfully complete training related to medical care and medication administration. OPWDD requires that agencies maintain AMAP certifications through annual recertification and clinical practicum.

At one IRA, a staff member completed his AMAP course in June 2016, however, on March 8, 2017, there was no evidence of his completion of the clinical practicum. Agency policy allows for 90 days following course completion to successfully pass the clinical practicum. At another IRA, a staff member was nearly three months overdue for recertification at the time of the review. These staff were assigned to administer medications without required AMAP certifications.

M. Agencies did not maintain staff CPR certifications.

All DDSOs reviewed require staff to be trained in CPR every two years.

Four of the six IRAs reviewed had issues related to CPR certifications. At one IRA, there was no evidence of CPR certifications for seven of the staff members on the master staff roster. At another IRA, a staff member was overdue for CPR training by nearly one year. At a third IRA, a staff member was nearly three months overdue for CPR training at the time of the review.

N. Agencies did not maintain staff First Aid certifications.

All DDSOs reviewed require staff to be trained in First Aid every two years.

Four of the six IRAs reviewed had issues related to staff First Aid certification. At one IRA, there was no evidence that seven of the staff members on the master staff roster received First Aid training. At another IRA, a staff member had been scheduled to take First Aid in July 2016, and at the time of the review, no evidence was provided that the course was completed.

**Documentation**
O. Agencies did not produce timely and specific House POPs.\textsuperscript{12}

House POPs are required to be updated at least annually and include basic information regarding the needs of people residing in the IRA. All plans reviewed did not specifically identify people residing at the IRA or their specific supervision levels, and three of the six plans reviewed were not dated. Additionally, one of the plans was dated for December 1, 2017. One IRA provided a document that was updated after the request for the plan was made by the Justice Center in March 2017. The agency originally provided an outdated plan from January 8, 2016.

P. Diagnoses were inconsistent in written plans.

Diagnoses were not consistently or completely listed in each of the written plans required for people receiving services. For example, one person’s IPOP states that he has Down Syndrome, but this relevant diagnosis is not included in his ISP. Another person’s ISP states that his sole diagnosis is profound intellectual disability. However, his IPOP states he also has gastroesophageal reflux disease, spastic quadriplegia, a history of urinary tract infections, and pneumonia. This same person’s MAR indicates he also has cataracts, constipation, chronic lower extremity dependent edema, and severe body contractures, which were not included in the plans noted above.

Q. Supervision levels were inconsistent and overly complex in written plans.

None of the DDSOs used consistent terminology when referencing supervision levels, nor did they consistently document the levels of supervision that people require in various settings. For example, one person’s IPOP states he only requires periodic observation every 60 minutes at the IRA, but also states he requires, “field of vision” supervision at the IRA. Another person who communicates solely through vocalizations and body movements, “…is confined to a wheelchair needing total staff support to transfer and/or move,” yet only requires 60 minute periodic checks by staff. A third person, who does not communicate verbally, has an ISP which states that he requires assistance from staff to ambulate, but only requires staff to check on him every 30 minutes. Another person’s ISP states that she must be observed for seizure activity and does not have an enhanced supervision level during waking hours. One person had seven different supervision levels depending on the circumstances and location, which brings into question how supervision can be accurately assigned, maintained, and understood by staff.

R. Required PONS were not reviewed or completed, as required.

An administrative memorandum published by OPWDD in January 2003, states that the RN, “…is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions.”\textsuperscript{13} These plans are required to be

\textsuperscript{13} OPWDD Administrative Memorandum - #2003-01 released in January 2003.
updated at least annually, or if there has been a significant change in the status of the person receiving services. The memorandum directs the RN to educate staff on the health care needs of people receiving services in their care.

A review of the PONS for all people in the sample revealed issues with the plans for 17 of the 18 people. PONS were not found to be individualized for each person, and the documentation was incomplete, not dated, or expired. At one IRA, the agency provided a PONS for a person with a prescribed diet that was inconsistent with his other written plans. At another IRA, PONS were not provided, as requested, for one person receiving services.

**Aging in Place**

S. Four people were required to move when their medical needs changed instead of being able to age-in-place.

A review of documentation revealed that four people had to relocate to a new IRA because of accessibility issues at the IRA they were living in or because the staffing levels were no longer adequate to meet the person’s needs. In the documentation reviewed, there was no evidence that proactive attempts were made to explore ways to allow people to remain in their homes.14

One person receiving services had to move because the person required two staff to assist with transferring and there were not enough staff at the current IRA to support this requirement. There were only two staff scheduled to work at the house, who were also responsible to provide enhanced supervision to other people at the home. Rather than assigning additional staff to work in the IRA, this person, who had lived in the IRA for 18 years, was moved out of the IRA.

Another person had to move after twenty years of living in the IRA, “…due to a physical decline.” A third person was moved, “…due to a change in residential medical status.” At this home, the Justice Center spoke with the Treatment Team Leader, who said that people who must be fed by a gastrostomy tube (G-tube) are typically moved to a specific house within the agency. A fourth person was moved due to a recent dementia diagnosis, and the ISP states that the person said, “I did not get to choose where I live.”

**Recommendations**

**Medication Administration Policies and Procedures**

14 On October 27, 2017 OPWDD provided a sample letter, which requests consent from the person receiving services or their personal representative to approve the recommended move. The letter also informs the person receiving services’ or their personal representative of their right to appeal the decision. A sample discharge summary was attached to the letter.
A. Implement a procedure to ensure MARs are accurately completed and reviewed, as required.
   1. Assess current practices for the review of the MAR and modify this procedure as necessary.
   2. Ensure that the required practices related to medication administration are followed.
   3. Ensure staff have received the proper training on how to properly document medication administration.
   4. Conduct administrative oversight to ensure that medications are administered as prescribed.

B. Evaluate agency practices to ensure that they align with the OPWDD AMAP protocols related to the Five Rights.
   1. Review agency practices regarding receipt of prescriptions and subsequent follow-up.
   2. Ensure that prescriptions include the person, medication, time, dose, and route prior to medication administration. Follow-up with the prescribing physician as needed.
   3. Ensure that MARs include the person, medication, time, dose, and route prior to medication administration.
   4. Provide more frequent training to staff.

C. Ensure staff comply with agency medication error policies.
   1. Review agency medication error policies and retrain staff.
   2. Review medication errors, identify trends, and provide training.
   3. Ensure medication error documentation is complete.
   4. Provide managerial oversight to ensure documentation is completed accurately.
   5. Ensure contemporaneous follow-up to medication errors to prevent harm to people receiving services and reduce the recurrence of similar errors.

D. Ensure adequate supplies of medications.
   1. Assess current policies related to the availability of medication.
   2. Review MARs and ensure all medications prescribed are available, including PRN and over the counter medications.
   3. Provide managerial oversight to ensure that all medications are available, including PRN and over the counter medications.
   4. Assess agency policies related to the supply of medication and make necessary changes to ensure an adequate supply of medications is available.
   5. Provide training to staff members on these policies.
   6. Provide managerial oversight to ensure these policies are being followed.

E. Ensure MARs are complete and accurate.
1. Review MARs to assess completion and accuracy regarding diagnoses, allergies, and diet orders.
2. Maintain communication with the pharmacy to ensure MARs are updated accurately.

F. Ensure self-medication assessments are updated on an annual basis or as needed.
   1. Review self-medication assessments for people residing in the home to ensure they are up-to-date and conduct assessments, as appropriate.
   2. Provide managerial oversight to ensure self-medication assessments are reviewed at least annually.

Medical documentation and medical equipment storage

G. Ensure medical equipment is stored properly, in working order, clean, and properly disposed of.
   1. Maintain an inventory of medical equipment agency-wide.
   2. Evaluate the cleanliness and confirm equipment is in working order.
   3. Submit work orders to move non-working or unused equipment from common areas of homes.
   4. Train staff on proper hygiene practices to ensure equipment is clean, and to submit work orders when necessary.
   5. Provide managerial oversight to ensure training is effective.

H. Ensure agencies follow the requirements for medication storage.
   1. Evaluate homes for the presence of expired medications and dispose of them, as necessary.
   2. Follow agency protocols on expired medications.
   3. Train staff on how to properly store medications and medical equipment.
   4. Ensure managerial oversight of medication and medical equipment storage.

Medical Appointments

I. Implement a system to organize and maintain medical documentation.
   1. Implement an effective system to organize and maintain medical documentation.
   2. Train staff on preparing and providing documentation that is required for medical appointments.
   3. Provide managerial oversight to ensure staff are using effective systems and understand the requirements.
J. Implement a system that efficiently tracks medical appointments and prompts the scheduling of necessary follow-up.
   1. Review medical appointments for people and ensure appropriate follow-up occurs.
   2. Develop an effective system to track medical appointments, including visits to urgent care and hospitalizations.
   3. Develop an effective system for scheduling follow-up appointments.
   4. Provide managerial oversight for appointment scheduling to ensure staff are assigned and available to take people to appointments.

Staff Training

K. Ensure staff assigned to administer medication have current AMAP certifications.
   1. Review AMAP certifications to ensure that staff members assigned to administer medication are certified.
   2. Provide more than the required level of training to staff members when warranted.
   3. Create a system to track required staff trainings.
   4. Create a system to ensure house management is notified about lapses in training.
   5. Provide oversight to house management to ensure untrained staff are not assigned to pass medication.
   6. Assess the availability of AMAP courses to ensure there are resources to train staff.

L. Ensure staff are certified in CPR.
   1. Review CPR certifications to ensure that staff members are trained.
   2. Provide more than the required level of training to staff members when warranted.
   3. Create a system to track required staff trainings.
   4. Assess the availability of CPR courses to ensure there are resources to train necessary staff.

M. Ensure staff are certified in First Aid.
   1. Review First Aid certifications to ensure that staff members are trained.
   2. Provide more than the required level of training to staff members when warranted.
   3. Create a system to track required staff trainings.
   4. Assess the availability of First Aid courses to ensure there are resources to train necessary staff.

Documentation
N. **Ensure House POPs are up-to-date, identify supervision levels and are reviewed at least annually.**
   1. Update plans to include the date, author, and supervision levels of the people in the home.
   2. Ensure House POPs are current.
   3. Provide managerial oversight to ensure House POPs are completed, as required.

O. **Ensure diagnoses are accurate in plans.**
   1. Ensure the treatment team reviews all plans for people receiving services to create accurate and consistent documents.
   2. Provide managerial oversight to ensure documents are accurate and consistent.

P. **Ensure supervision levels in plans are accurate, consistent, and feasible.**
   1. Ensure the treatment team reviews all plans for people receiving services to create accurate and consistent documents.
   2. Provide managerial oversight to ensure documents are accurate and consistent.
   3. Ensure staff assignments are reasonable.
   4. Minimize variability in supervision levels, as possible.
   5. Standardize the definitions of supervision levels.
   6. Train staff on supervision levels and the supervision levels of the people they work with at the home.

Q. **Ensure people have up-to-date PONS that are individualized.**
   1. Ensure that people have a PONS for each of their diagnoses.
   2. Ensure PONS are individualized for the people receiving services.
   3. Ensure the implementation date of the PONS is documented on the plan.
   4. Train staff on all PONS for people in the homes, as required.
   5. Update PONS annually, as required.
   6. Provide managerial oversight to ensure that PONS are reviewed at least annually and that staff are trained.

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**Aging in Place**

R. **Allow people receiving services to age in place.**
   1. Identify people who may require added support in the near future and begin to develop a plan to meet their needs.
   2. Engage the person and treatment teams to identify solutions which allow the person to remain in the home if that is where they want to remain.