

Family Care Program Monthly Checklist

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|---|---|
| New York State Office for People With Developmental Disabilities Form 239 (Rev. April 2019) | Date of Visit: ____/____/____ Time: ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM Individuals Present: <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|---|

| | | | |
|-------------------|--|--|--|
| Provider Name: | | Operating Certificate #: | |
| Co-Provider Name: | | Operating Certificate Expiration Date: | |
| Address: | | Sponsoring Agency/DDS00: | |
| Telephone: | | Family Care Home Liaison: | |

Individuals in Family Care Home

| |
|----|
| 1. |
| 2. |
| 3. |
| 4. |

I. Physical Plant

A walk-through must be conducted to ensure the safety of all individuals in the home. All safety equipment must be operational. Review of required documentation must occur and discussion with the Family Care Provider and the individuals present is required to determine compliance.

| | | Yes | No | Comments |
|-----|---|-----|----|----------|
| 1a. | Are smoke detectors present and in working order; in each bedroom, in each corridor adjacent to the bedrooms, in corridors adjacent to open areas such as living areas/dining rooms, at the head of each stairwell and in the basement? If no what corrective action was taken. | | | |
| 1b. | Are there working carbon monoxide detectors present and operational on every level with a CO source and near each sleeping area? | | | |
| 1c. | Have the smoke detectors and carbon monoxide detectors been tested monthly? Remedied if not operational? | | | |
| 2a. | Is there a fire extinguisher in or near the kitchen? | | | |
| 2b. | If the structure has a basement with habitable space, is there an extinguisher on that level? | | | |
| 2c. | Do the fire extinguishers appear in operable condition (i.e gauge in green zone, no outward sign of damage)? | | | |

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| | Physical Plant (continued) | Yes | No | Comments |
|-----|---|-----|----|------------------------------------|
| 3a. | Are there any space heaters in use as the sole method of heating? If yes, indicate location in Comments. | | | Location: |
| 3b. | Has the use of these space heaters as the sole method of heating been approved for a time limited period by the Commissioner's Designee (DDSOO Director)? If no, explain in Comments. | | | |
| 4a. | Were there any recommendations made during the last Safety Inspection? | | | |
| 4b. | If yes, have all recommendations been remedied? If no, what is the action plan to address? | | | |
| 5a. | Are extension cords or power strips in use? | | | |
| 5b. | If yes, are they overloaded, in traffic areas which present a safety hazard, strung together to reach an outlet, hot to the touch or otherwise used improperly? | | | |
| 5c. | If 5b is yes, list immediate action steps to remedy the situation. | | | |
| 6. | Are dangerous household products and flammable liquids stored properly to avoid safety hazards? If no, list immediate action steps to remedy the situation. | | | |
| 7a. | Is the Evacuation Plan current? | | | |
| 7b. | Does the Evacuation Plan address the needs of all individuals in the home? | | | |
| 7c. | Was a fire drill completed within the last month? List date in the Comments. | | | Date of last drill: |
| 7d. | In reviewing the last fire drill, were there any identified problems? If yes, what follow up was done? List names of people spoken to, date/time, etc. | | | |
| 7e. | One fire drill must be conducted while individuals are asleep. Has this drill been conducted this year? If yes, list date and time in Comments. | | | Date of last sleep drill: Time: |
| 7f. | One fire drill must be observed each year. Has this drill been conducted? If yes, list date in Comments. | | | Date of last observed drill: |
| 8a. | Date of annual Furnace inspection: | | | |
| | Date of annual Well-water test (if applicable): | | | |
| | Date of annual Central Air inspection (if applicable): | | | |
| 8b. | Were any issues identified during the above inspections? If yes, indicate plan to correct in Comments. | | | |
| 9a. | Water Temperature: _____ *F <i>Test during each monthly visit using water thermometer</i> | | | |

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| | Physical Plant (continued) | Yes | No | Comments |
|------|---|-----|----|----------|
| 9b. | Was water temperature 120°F or above? If yes, indicate protections in comments. | | | |
| 10. | Does the home contain any hazardous conditions (e.g. loose tiles, loose handrails, worn stair threads, loose/torn carpet, burned out bulbs, garbage not properly contained, unlicensed or unvaccinated pets, etc.)? If yes what is the response/protection? | | | |
| 11. | Does the home contain clutter, (e.g. piles of newspapers, magazines, old furniture, boxes, clothing, etc.) that may pose a fire, fire evacuation or trip hazard to individuals? If yes what is the response/correction? | | | |
| 12. | Is the overall appearance of the home and grounds acceptable? | | | |
| 13a. | Is there evidence of modifications or renovations to the home? If yes, have they been reported to and reviewed by the Sponsoring Agency? | | | |
| 13b. | Is there a building permit in place for the modifications/renovations? | | | |
| 13c. | Do the modifications/renovations pose a risk or adverse impact to the Family Care individuals? If yes what action was taken? | | | |
| 14a. | Are there any firearms present in the home? | | | |
| 14b. | If yes, are they secured in a locked cabinet/safe? | | | |
| 14c. | If firearms are present, is ammunition secured in a separate location? | | | |

II. Individual Services

A review of individual services and overall wellbeing is important to the functionality of a Family Care Home. Discussions with Family Care Providers and individuals as well as documentation review are required.

| | | Yes | No | Comments |
|-----|--|-----|----|----------|
| 1. | Are individuals clean, well-groomed, and given the opportunity of choice on clothing selections? | | | |
| 2a. | Are individuals assisted with personal hygiene and grooming, as necessary? | | | |
| 2b. | Are Residential Habilitation/Staff Action Plans understood and implemented by the provider? | | | |
| 2c. | Is a daily Residential Habilitation/Staff Action Plan checklist available for each individual in the home? | | | |
| 3a. | Is there a current ISP/Life Plan (with approvals) for each individual in the home? | | | |
| 3b. | Is the Family Care service listed correctly in the Life Plan? | | | |

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| | Individual Services (continued) | Yes | No | Comments |
|------|---|-----|----|----------|
| 4. | Are individual's furnishings in good condition, with adequate sheets, pillowcases, and blankets on hand? | | | |
| 5. | Are individuals' bedrooms personalized and/or based on his or her preferences? | | | |
| 6. | Are bed rails being used? If so, is their use reflected in the individuals plan of services? | | | |
| 7. | Is there any indication that any of the individuals are isolated, abused, or neglected? | | | |
| 8a. | Were any incident reports completed this month? If yes, explain in Comments. | | | |
| 8b. | Were sufficient protections put in place in regards to the incident? | | | |
| 9. | Do individuals and the Provider interact as a family (e.g. dining, community activities)? | | | |
| 10. | Are community inclusion goals being met? (Review of outings.) | | | |
| 11a. | Are supervision levels of individuals reflected in Safeguards section of the Staff Action Plan, ISP/Life Plan? | | | |
| 11b. | Are these supervision levels and safeguards being followed? | | | |
| 11c. | Verify that dietary/food modifications, supervision needs, and adaptive equipment have been used as recommended. (Observation of a meal/snack should occur at least once each year) | | | |
| 12. | Were there any unusual changes in bus schedule or problems with day services or employment? If yes, explain in Comments. | | | |

III. Health Care Considerations

Medical oversight is extremely important to the health and safety of all individuals. Verification should be done through discussions, record review, and inventory. Medication Administration Records (MAR) must be checked against all medications in the home. Issues identified must be reported to the Family Care Registered Nurse (RN) for appropriate corrective actions.

| | | Yes | No | Comments |
|-----|---|-----|----|----------|
| 1. | List dates of medical appointments (physician, dental or medical specialist visits) this month. Are individual's medical needs being met? (Appointments being made/kept by provider?) If more space is needed, list this information in Notes on page 9. | | | |
| 2. | Any instance of illness or hospitalization? If yes, explain in Comments. | | | |
| 3a. | Any medication changes this month? | | | |
| 3b. | If yes, has the RN been notified? | | | |
| 4a. | Are the Medication Administration Records (MAR) completed accurately to show when medications were given? | | | |
| 4b. | Are all medications present in the home as listed on the MAR? | | | |

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| | Health Care Considerations (continued) | Yes | No | Comments |
|---|---|-----|----|--------------|
| 4c. | Do all medications and dosages listed on the MAR match the prescription container? | | | |
| 5. | Are all medications stored properly? | | | |
| 6. | Are diets appropriate to the individual's needs and implemented as written? | | | |
| IV. General | | | | |
| A review of the overall monthly status of a Family Care Home is important to ensure proper day to day operations. This must occur through discussion with the Family Care Provider and individuals in the home as well as record reviews. | | | | |
| | | Yes | No | Comments |
| 1a. | Has respite been required this month? | | | |
| 1b. | If yes, has Family Care staff met the approved/certified Substitute Provider? | | | |
| 1c. | Where was respite provided? Specify in Comments. | | | |
| 1d. | How long was respite provided? Specify in Comments. | | | _____ day(s) |
| 1e. | If longer than 5 consecutive days, did Family Care staff visit the home to ensure health & safety? | | | |
| 2. | Has the Family Care Provider provided overnight respite in the home this month? | | | |
| 3. | Has the home's certified capacity been exceeded? (Certified capacity includes the permanent beds AND respite beds) | | | |
| 4a. | How many people, including individuals and family members, are living in the home? | | | #: _____ |
| 4b. | If any household changes, list name(s) and age(s): | | | |
| 4c. | Have appropriate parties been notified of these changes? | | | |
| 4d. | Have the household changes impacted the care and treatment of the individuals receiving Family Care services? Please comment. | | | |
| 5. | Were/are there long-term guests that have regular contact with the individuals in the home? If yes, explain in Comments. | | | |
| 6. | Have all adults (18 and over) been fingerprinted? *This does not include service recipients. * If no, explain in Comments. | | | |
| 7. | Have all adults (18 and over), been cleared through the State Central Register and Staff Exclusion List? | | | |
| 8. | Is the Family Care Provider current with all training? If no, please explain in Comments. | | | |
| 9. | Have there been any significant changes in the home that may affect the individuals (e.g. divorce, health issues, loss of income, legal involvement, household changes, actions or proceedings)? If yes, explain in Comments. | | | |

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V. Fiscal

A review of individuals finances should be performed to maintain program integrity. All money should be accounted for with receipts, ledgers, or cash on hand. A careful review of all records must occur.

| | | Yes | No | Comments |
|-----|---|-----|----|----------|
| 1. | Does the Family Care Provider maintain accurate deposit/expenditure records that are updated as needed, with receipts as necessary for each individual? | | | |
| 2. | Do Personal Allowance ledgers reflect the correct monthly personal allowance? | | | |
| 3. | Are expenditures based on individual choice and/or need? | | | |
| 4. | Is an updated inventory of personal items/belongings kept for each individual? | | | |
| 5. | Does cash on hand match the ledger balance? Calculations checked? | | | |
| 6. | If cash on hand exceeds \$_____, what is the spend-down plan? | | | |
| 7. | Date of Personal Expenditure Plan (PEP): | | | |
| 8. | Date of Money Management Assessment (MMA): | | | |
| 9. | Does each individual have their own bank account? Is it in their name? | | | |
| 10. | Are all bankbooks up to date? | | | |
| 11. | Do any individuals have credit cards or gift cards? If so, where are they kept? | | | |

| | | | Bank Account Balance (Individual's Name Only) | |
|------------|--------------|--|---|----------------|
| Individual | Cash on Hand | Earned Income (Verify Source & Frequency) | Amount | Statement Date |
| 1. | \$ | | \$ | ___/___/___ |
| 2. | \$ | | \$ | ___/___/___ |
| 3. | \$ | | \$ | ___/___/___ |
| 4. | \$ | | \$ | ___/___/___ |

Fiscal Comments:

VI. Community Inclusion Activities During the Month

List the individual's names and activities:

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|----|
| 1. |
| 2. |
| 3. |
| 4. |

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VII. Issues Identified, Corrective Action, Follow Up Needed

VIII. Comments

Note: The Family Care Home Liaison should promptly report any concerns about the condition of the home and/or the care and treatment of the individual's receiving Family Care services as required.

| | |
|--|--------------|
| Family Care Provider Signature: | Date: |
| Family Care Home Liaison Signature: | Date: |
| Family Care Coordinator/Designee Signature: | Date: |
| Other Staff Signature (if applicable): | Date: |

Family Care Program Monthly Checklist

**Family Care Inspection Report
Action Plan to Correct Identified Issues**

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|---------------------------------|
| Family Care Provider: |
| Operating Certificate #: |
| Address: |
| Inspection Date: |

| Section # | Question # | Action Plan to Correct Identified Issues | Planned Completion Date | Actual Completion Date |
|-----------|------------|--|-------------------------|------------------------|
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|---|--------------|
| Signature of Family Care Provider: | Date: |
| Signature of Family Care Home Liaison: | Date: |
| Signature of Family Care Coordinator: | Date: |
| Other Staff Signature (if applicable): | Date: |

