



Date of Visit:	Operating Certificate Number:	Operating Certificate Expiration Date:
Mark all that apply: <input type="checkbox"/> State Sponsored <input type="checkbox"/> Agency Sponsored <input type="checkbox"/> Announced Visit <input type="checkbox"/> Unannounced Visit <input type="checkbox"/> Recertification Visit		
I. Provider Information		
Provider Name:		Co-Provider Name:
Address:		Telephone:
Sponsoring Agency or DDSOO:		Telephone:
Does the Provider own the home? Yes No If no, please explain:		
Type of home: Single Family Multi-Family Is the home a trailer or mobile home? Yes No		General condition of the home: Good Needs Repairs Other, please explain:
Type of Neighborhood:	Residential Commercial Industrial Rural Mixed	
Family Composition: Spouse Yes No Living in home Living elsewhere Children: Yes No Living in home Living elsewhere Others: Yes No Please explain:		
Have there been any significant changes in the home that may impact the individuals? (Divorce, loss of job, loss of lease, new household members, etc.) Yes No If yes, please explain:		
II. Information on Family Care Individuals		
Name	Date of Birth	

III. Home and Environmental Information

A walk-through of the entire home 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.

A. Characteristics of the Home		Yes	No	N/A	Comments
1a.	What is the certified capacity of the home? (Certified capacity includes the permanent beds AND respite beds)				Certified Capacity:
					Respite Beds:
1b.	Does the number of individuals receiving services in the home exceed the certified capacity?				
2a.	Is the provider licensed or certified by another agency to provide in-home care to others?				Name of Agency:
2b.	If yes, is there an agreement between the agencies and the provider, defining the terms and conditions of sharing the home?				
2c.	Do any of these individuals require personal care oversight from the Family Care Provider? If yes, explain under comments.				
2d.	Does this additional arrangement have any adverse impact to the care and treatment of the Family Care individuals?				
3.	Does the provider reside at the same address, within the same living unit, not a separate apartment?				
4.	Are furnishings and equipment adequate and safe for the size and needs of family members and individuals?				
5.	Is the interior of the home in acceptable condition? If no, explain. (Do walls need painting, flooring torn/soiled requiring replacement?)				
6.	Is the interior of the home clean and odor free?				
7.	Are kitchen supplies and food properly stored?				
8.	Are individuals' rooms adequately heated by a central heating source?				
9.	Is each individual's bed and furnishings in good condition with adequate linens?				
10.	Does the home meet the needs of those individuals with physical, sensory or behavioral disabilities? If no, explain under comments.				
B. Physical Plant		Yes	No	N/A	Comments
1.	Are smoke detectors installed in each corridor adjacent to bedrooms/sleeping areas?				
2.	Are smoke detectors installed in all bedrooms/sleeping areas?				
3.	Is there at least one smoke detector installed in the basement?				
4a.	Is the basement subdivided by partitions?				
4b.	If yes, are there additional smoke detectors installed?				

B. Physical Plant (continued)		Yes	No	N/A	Comments
5.	Are smoke detectors installed in corridors or in adjacent open areas, such as a living room, dining room or recreation room?				
6.	Is a smoke detector installed at the head of each open stairway located within the home or within six feet of the bottom opening of a stairway that is enclosed at the top?				
7.	Are carbon monoxide detectors installed within 15 feet of each sleeping area, regardless of level within the structure?				
8.	Are carbon monoxide detectors installed on every level with a carbon monoxide source and within a reasonable distance to the source?				
9.	Are all smoke detectors and carbon monoxide detectors in working order?				
10.	Are smoke detectors and carbon monoxide detectors tested monthly and remedied if not operational?				
11.	Is there at least one fire extinguisher in or near the kitchen area that meets the requirements of NFPA 10 and is UL labeled and approved?				
12.	If the structure has a basement with habitable space, is there a fire extinguisher on that level?				
13a.	Is there a fire evacuation plan in the home?				
13b.	Is a fire drill evacuation drill completed and documented monthly?				Date of last drill:
13c.	Is it rehearsed at different times of the day?				Date of last sleep drill:
13d.	Has a drill been observed by the Family Care Home Liaison?				Date of last observed drill:
13e.	Were there any identified problems during drills and if yes, were steps taken to address the problematic drill?				
14a.	Is there verification that no bedroom is in the attic, hallway or other non-inhabitable space?				
14b.	Are bedrooms adequate in size to provide a reasonable degree of privacy?				
14c.	Are bedrooms adequate in size to accommodate the individual(s), furnishings and possessions?				
15a.	Does the home utilize portable space heaters as the sole source of heating?				Location:
15b.	If yes, was the portable space heater approved by the Commissioner's Designee (DDSOO Director) for a time-limited period?				
16.	Is there evidence of vermin or insect infestation, etc. at the home?				

B. Physical Plant (continued)		Yes	No	N/A	Comments
17.	Are all dangerous household products, flammable liquids, chemicals, caustics, toxic items and highly combustible materials stored in a safe manner out of reach of the individuals?				
18.	Does the home contain clutter (piles of newspaper, magazines, old furniture, boxes, clothing, etc.) that may pose a fire, fire evacuation or ambulation hazard to individuals?				
19.	Does the home contain any hazardous physical conditions (loose tile, loose handrails, worn stair treads, loose carpeting, burned out bulbs, exposed wiring, unvaccinated or unlicensed pets)?				
20.	Is trash/garbage kept in metal or plastic containers with properly fitted covers and disposed of on a regular basis?				
21a.	Are extension cords in use?				
21b.	If yes, are they overloaded, hot to the touch, in traffic areas which present a safety hazard, strung together to reach an outlet or otherwise used improperly? If yes, correct immediately and notify Family Care Team for follow up.				
22.	Is the home equipped with GFCI within 6 feet of bathroom and kitchen sinks, and other water sources (e.g. swimming pool)?				
23a.	Are there antiscald devices or a mixer valve in place as required? Antiscald Mixer valve (<i>Test using water thermometer</i>)				Water temperature(*F): _____ Location: _____
23b.	If no, is an exemption approved by the DDSOO Director or designee? Are protections/safeguards documented for the individual(s)?				
24a.	Is the provider making or planning to make any modifications to the home? If yes, what modifications are planned?				
24b.	Are modifications free of hazardous physical conditions?				
24c.	Will the modifications have an adverse impact on the individuals?				
24d.	Has a building permit been issued for this work?				
25.	Are there firearms kept in the home? Locked up? Is ammunition secured in a separate location?				
26a.	Was an annual Safety Inspection completed by OPWDD?				Safety Inspection Date:
26b.	Are all issues identified during the annual Safety Inspection remedied? If not, explain why:				

B. Physical Plant (continued)		Yes	No	N/A	Comments
27a.	Date of Annual Furnace Inspection:				
27b.	Date of Alternate Heat Source Inspection:				
27c.	Date of Family Care Provider Agreement for an Unused Fireplace/Woodstove or Fuel Burning Appliance:				
27d.	Date of Central Air Inspection:				
27e.	Date of Annual Well Water Testing:				
C. Services and Oversight		Yes	No	N/A	Comments
1.	Has a Care Manager (CM) visited the home?				Date of Last CM Visit:
2.	Are current ISPs/Life Plans with approvals in the home?				
3.	Is the Family Care service listed correctly in the Life Plan?				
4a.	Is there a current list /reference to required safeguards in the home for each individual? Are they being implemented as written?				
4b.	Are current Residential Habilitation/Staff Action Plans in the home?				
5a.	Are Residential Habilitation/Staff Action Plans understood and implemented by the provider?				
5b.	Is a daily Residential Habilitation//Staff Action Plan checklist available for each individual in the home?				
6.	Are they maintained by the provider on a daily basis?				
7.	Is supervision of each individual's activities provided as required?				
8.	Are individuals who require help in activities given assistance by the provider?				
9.	Does each individual have leisure activities and appropriate equipment for such activities?				
10.	Is the provider knowledgeable of the whereabouts of the individuals when they are away from home and their expected time of return?				
11.	Are leisure/recreational activities consistent with the individual's Life Plan/Staff Action Plan?				
12.	Is transportation available by the provider or others to support all components of the Life Plan/Staff Action Plan?				
13.	Do individuals receive appropriate personal hygiene such as tooth brushing, hair grooming, etc. with the assistance of the provider as necessary?				
14.	Are there adequate personal hygiene supplies for each individual?				

C. Services and Oversight (continued)		Yes	No	N/A	Comments
15a.	Were Family Care individuals present during the visit? If yes, list names in Comments.				
15b.	If present, were the individuals clean and well groomed? If no, explain in Comments.				
16.	Is clothing clean and appropriate to age, season and selected by the individual?				
17.	Do individuals have sufficient and appropriate clothing for a weeks' wear?				
18a.	Do any individuals have dietary/food modifications, supervision needs, and/or adaptive equipment for meal time? If yes, indicate names in Comments.				
18b.	If yes, has a meal/snack been observed by a member of the team during the past year to verify diet orders/items are carried out as recommended?				
19a.	Do individuals have a choice in selecting meals and snacks?				
19b.	Is there a Personal Expenditure Plan (PEP) for each individual in the home? If no, explain in Comments				
19c.	Do individuals have choice in the way they save and spend their personal allowance and earnings?				
20a.	Does the provider maintain an updated personal allowance record with receipts as necessary for individual's expenditures of funds?				
20b.	Is there a Money Management Assessment (MMA)for each individual in the home? If no, explain in Comments				
20c.	Is the PEP consistent with the MMA?				
	Individual	Cash on Hand	Does individual have a personal bank account? (Y/N)		Bank Account Balance
		\$			\$
		\$			\$
		\$			\$
		\$			\$

C. Services and Oversight (continued)		Yes	No	N/A	Comments
21.	Has the provider completed all required training in the past year? If no, explain in comments.				
22a.	Is an approved substitute provider available for the primary provider's absence? If no, explain.				
22b.	Has the substitute provider received training based on the needs of the individuals?				
22c.	Has respite been provided since the last visit?				Emergency: Planned:
22d.	Was the respite provided in the home or at another approved location?				Home:
22e.	How long were respite services provided?				Other location:
22f.	If longer than 5 consecutive days, did staff visit the home to ensure health, safety, etc?				Dates:
23.	Has a nursing visit occurred at least every 90 days or more often based on individual(s) needs?				Date of visit:
24a.	Is there a current Medication Administration Record (MAR) in the home for each individual?				
24b.	Is the MAR maintained on a daily basis by the provider?				
24c.	Are all medications listed on the MAR present in the home?				
24d.	Is the dosage and frequency listed on the MAR consistent with the pill bottle?				
25.	Are individual specific medication information sheets available for each medication in the home?				
26.	Is a Self-Medication Assessment in the home?				
27.	Is supervision of medication administration appropriate to meet the individual's needs as documented in the IPOP/safeguards?				
28.	Is appropriate storage provided for medication?				
29.	Are prescriptions filled in a timely manner?				
30a.	Any medication changes this month?				
30b.	Is the nurse aware of the medication change?				
30c.	Has the change been initiated?				
30d.	Did the individual experience any side effects?				
30e.	Does the provider feel knowledgeable with the new medications, instructions and side effects?				
31.	Is informed consent being implemented as required?				

C. Services and Oversight (continued)		Yes	No	N/A	Comments
32a.	Are individual's medical needs being met? (Appointments being made and kept, follow up being provided?)				
33.	Any instances of individual illness in the past 3 months?				
34.	Does the Sponsoring Agency have a written plan for how the provider will address life-threatening emergencies?				
D. Rights		Yes	No	N/A	Comments
1.	Is there any indication that any of the individuals are abused or neglected or isolated from other individuals? If yes, explain:				
2.	Has an incident report been completed within the past year? Were appropriate protections implemented?				
3a.	Have any rights been limited for disciplinary purposes or for the convenience of the provider?				
3b.	Are individuals allowed to have visitors or to visit outside of the home?				
3c.	Are individuals allowed to communicate by letter or telephone without censorship?				
3d.	Are individuals allowed to access family planning services?				
3e.	Are individuals allowed to attend religious services of the individual's choice?				
3f.	Do individuals have the opportunity to participate in religious activities and to have visits in the home from clergy or other religiously affiliated persons?				
3g.	Are individuals allowed to contact their Care Manager?				
4a.	Do any individuals share a bedroom?				
4b.	If yes, are there more than 2 individuals in a room?				
5.	Have any changes in sleeping arrangements been reported?				
6.	Is there evidence that individual sleeping arrangements have been changed since the last visit?				
7.	Are each individual's possessions readily accessible, available and adequate?				
8.	Is the individual's bedroom personalized? If not, explain.				
9.	Does each individual have access to areas of the home where they can be afforded privacy when needed?				
10.	Is there an area for an individual to visit with family and friends?				
11.	Does the Sponsoring Agency have mechanisms in place to address Home and Community Based Services (HCBS) waiver standards? (i.e. to assess living arrangement choice, roommate satisfaction)				

IV. General Comments

V. Recommendations

<hr/>	<hr/>	<hr/>
Print Name/Title of Person Completing this form	Signature of Person Completing this form	Date completed
<hr/>	<hr/>	<hr/>
Print Name/Title of Person Reviewing this form	Signature of Person Reviewing this form	Date reviewed

**FAMILY CARE HOME EVALUATION AND SURVEY
DEFICIENCY REPORT & VERIFICATION OF CORRECTION FORM**

INSTRUCTIONS:

1. Deficiencies must be reviewed with the Family Care Provider during the visit.
2. Within 10 calendar days of the visit, the Family Care Provider must receive a copy of the *Family Care Home Evaluation & Survey Deficiency Report and Verification of Correction*.

Family Care Provider:

Date of Visit:

[] CHECK IF THERE ARE NO DEFICIENCIES DURING VISIT

Section	Item #	What is the deficiency? Please describe the issue. Provide examples, when applicable.	If <u>Imminent Danger</u> , list immediate protective measures and notifications made.	What is the plan to correct the deficiency? Include plan to prevent similar future deficiencies.	Date corrective action was/will be completed (month/day/year)	Title of person who will verify corrective action completed and how it will be verified (e.g. home visit, record review)

Family Care Provider Signature:

Date:

Signature/title of person writing report:

Date:

**PLEASE ANSWER THE FOLLOWING QUESTIONS FOR
WILLOWBROOK CLASS MEMBERS ONLY**

QUESTION	YES	NO	COMMENTS
A.) Does the Class Member have a Care Manager who is a Qualified Intellectual Disabilities Professional (QIDP)? If no, please explain under comments.			
B.) Is the Care Manager meeting with the individual monthly?			
C.) Does the Care Manager case ratio meet the guidelines of the Willowbrook Permanent Injunction? (1:20 for Family Care) If no, please explain under comments.			
D.) Is the Willowbrook Class Member, who is non correspondent or who is lacking active participation by a correspondent, receiving "active representation by co-representation by Community Advisory Board?" If no, please explain under comments.			
E.) Does the Willowbrook Class Member's permanent file contain the "Notice of Rights" statement describing individual's rights and entitlements under the Permanent Injunction? If no, please explain under comments.			
Recommendations:			
Completed by:			Date:
Reviewed by:			Date: