

**Office of Health Care Quality
Residential Crisis Survey Tool
Alternative, Prevention & Foster Care**

Licensee Name			
Name of Surveyor		Affiliation	
Agency Contact			
Contact Number			
Type of Survey		Date of Survey	
CSA		Contact Number	
Administrative Staff			
Program Director :			
Site 1		Site 2	Site 3
Psychiatrist			
Treatment Coordinator			
Program Information - Number of TFC Homes: Ages: Gender:			
1	Program Name		Type of RCS
	Program Address		Child/Adult
	Number of Residents		Gender
2	Program Name		Type of RCS
	Program Address		Child/Adult
	Number of Residents		Gender
3	Program Name		Type of RCS
	Program Address		Child/Adult
	Number of Residents		Gender
Program Overview			
	Site 1	Site 2	Site 3
Medication Protocol monitor/administer 10.21.26.09			
•Does the RCS utilize 10.21.12 Seclusion/ Quiet room •Restrains as a treatment method? •What Types of restraint utilized •Number of times	Seclusion Quiet room Restrains		
Staffing Schedule 10.21.26.09 24 hour awake-overnight 1:4 adults 1:3 children 1:1 PRN 10.21.26.10	DAY Evening Night Weekends		
	Site 1	Site 2	Site 3

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Program Hours <u>Director Program</u> Min 10 hrs a week Contact with each site each weekly 10.21.26.08 <u>Psychiatrist-On Call 24/7 & Mental Health Prof.</u> (Alternative only)10.21.26.10												
Menu: Who designs the menu? 14.31.06.10 menus kept on file for 3 years & approved by Dietician												
How often does the agency visit the foster parents? (2x month) 07.02.21.08												
Board of Directors/Advisory Committee 10.21.17.03 1/3 Community/Meet Quarterly												
Program File Review												
Fire Logs - alternate shifts within quarter Child – every 3 months adult 14.31.06.08												
Site 1			Site 2			Site 3						
Date	Time	Evacuation time	Date	Time	Evacuation time	Date	Time	Evacuation time				
			Site 1			Site 2			Site 3			
Fire Survey – (6 beds or more) 14.31.07.07 .07A4 ????												
Lead Paint, Asbestos, radon (Child Only) ????												
Water test if not public water 14.31.06.07 N (4) (Child Only)												
Fleet Insurance 14.31.06.08 D												
Fire, Liability, Hazard Insurance ???												
Treatment Foster Care Approval by DHR 7.02.21												
Individual File Review												
1	RCS Program						Date of Birth					
	Name of Resident						Date of Admission					
	Medicaid Number											

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2	RCS Program		Date of Birth	
	Name of Resident		Date of Admission	
	Medicaid Number			
3	RCS Program		Date of Birth	
	Name of Resident		Date of Admission	
	Medicaid Number			
Program Model		Resident 1	Resident 2	Resident 3
Home like environment				
10.21.22.03 C 4 Initial Certification				
Did the Residential Specialist certify the residence within 5 days of the inspection				
Was the residence certified with General Approval, Provisional Approval or Not Approved				
14.31.06.18 B (Child Only)				
Face Sheet				
Current Photo				
10.21.17.06 Record Maintenance				
Contents include – Identifying information Name, sex, age, marital status, DOB				
Source of and Reason for referral				
Address and Telephone number				
Emergency contact				
Acceptance and initial service dates				
Source of referral				
Aftercare plan if discharged from inpatient				
Present and history of presenting problems				
Prior Treatments				
Eligibility 10.21.26.05				
Did the Resident agree to, in writing, a willingness to comply with the GH Rules and Regulations				
Services Pre-Authorized by the ASO				
Has a Mental Disorder				
Eligibility For Prevention Only				
Is at risk for inpatient				
Eligibility For Alternative Only				
Is a danger to self or others				
Would be placed in patient or not discharged from inpatient RCS without				
Eligibility For Foster Care Only				
Is in need of a high level of treatment				

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Screening assessment 10.21.26.05 B			
Assesses needs and willingness to participate			
Documents the diagnosis			
Medications (if applicable)			
Preliminary plan			
Level of staff support			
Type of support			
Inform individual of rules			
Process for discharge			
Parent signs agreement to accept child upon discharge			
Initial Evaluation 10.21.26.06 A			
Presenting problem and history			
Medical and mental health history			
Previous inpatient and outpatient treatment			
Current medications			
Mental status			
Confirm or develop diagnosis			
Identify needed treatment			
Assessment 10.21.26.06 B			
Identify strengths needs and desires			
Level of functioning			
Family and social supports			
Legal status			
Employment and economic status			
Substance abuse			
Physical and sexual abuse			
History of violence and assault behaviors			
Natural supports			
Activities of daily living			
If the Individual Is an Child			
Interpersonal skills			
Child development status			
Educational history& current placement			
Involvement with other agencies			
Home environment			
Family history, status, legal custody			
ITP			
Includes Treatment Coordinator Staff Responsible Individual Guardian (if Child)			

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Within 24 Hours of Placements			
Includes Diagnosis			
Description of current behavior symptoms			
Strengths needs treatment expectations and responsibilities			
Family/Significant others strengths and needs			
Treatment Goals including transition and discharge			
Goals measurable			
Anticipated length of stay			
Treatment Modalities			
Modality and frequency			
Target dates			
Staff responsible			
Identify Daytime programs			
Role of Foster parent 07.02.21.11			
Signatures			
Treatment coordinator Individual (guardian)			
Psychiatrist			
Inpatient Admission Prevention(only) ITP Should Identify 10.21.26.09			
Supportive counseling that focuses on Includes: assessment and definition of problem			
Planning and goal setting			
Development of effective problem solving			
Evaluation of progress			
Continued Evaluation 10.21.26.07 B			
Contact notes			
Daily Progress Summary Notes			
Progress towards goals			
Changes in goals and interventions			
Rationale for the changes			
Weekly progress And behavior notes (TFC)???			
Daily contact recorded by Mental Health Professional (Alternative Only)?????			
14.31.06.13 Required Services(Child Only – 30 days or more)	Resident 1	Resident 2	Resident 3
Dental exam within 1 year of admission or within 30 Days			
Follow up completed (If applicable)			
Physical within 30 Days of admission			
Follow up completed (If applicable)			
Immunization record present			

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Somatic care ????			
within 72 hours medical appt Assess physical health Determine if a physical is needed			
10.21.07.12 D. Medication Services ??for TGH			
Medications stored securely			
Monitor Compliance with taking medication			
Read Label to assure each container is labeled with the contents child's name, directions for use, and expiration date			
Reinforce education on the role and the effects of medication symptom management			
Additional Comments			

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Personnel Records 10.21.17.08

Highlighted are For Children Only

Licensee:						
Program Type:						
	Staffs Name	Position			Staff Initials	
1						
2						
3						
4						
5						
6						
		Staff # 1	Staff # 2	Staff # 3	Staff # 4	Staff # 5
	Staff Initials					
	Date of Hire					
	Application/Resume					
	Three (3) References					
	Medical exam at hire					
	I-9 ???					
	Annual TB/medical certification					
	Criminal Background check					
	Child protective services Check					
	Professional Credentials Child - High school or equivalent					
	Annual Performance Eval.					
	Drivers License					
	Annual Driving Record					
	Valid Automobile insurance					
	Personnel Action/if Applicable					
	Received and Read P & P regarding child abuse, neglect and discipline (m)					
	Job Description Available 14.31.06.05 D 1					
	Verification of Hours Worked					
	Orientation within 3 months					
	Orientation includes 10.21.17.09					
	1. Individual rights					

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2. Psych and medical emergency protocol including crisis management and suicide						
3. P&P						
4. Overview of service delivery system						
5. Required trainings						
6. EEO Policy						
Initial Trainings Within 3 months	Staff # 1	Staff # 2	Staff # 3	Staff # 4	Staff # 5	Staff # 6
Emergency Preparedness						
CPR						
First-aid						
Suicide Risk/Prevention						
Behavior Modification						
Family Interventions						
Crisis Intervention						

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Personnel Trainings – Direct Care Staff 14.31.06.05 F							
<i>Alternative and preventative only Highlighted Residential Child Only</i>							
Licensee:							
	Staffs Name	Position			Staff Initials		
1							
2							
3							
4							
5							
6							
Caseworkers 07.02.21.05	Staff # 1	Staff # 2	Staff # 3	Staff # 4	Staff # 5	Staff # 6	
20 Hours pre-service trainings							
Overview History Development Permanency							
Treatment philosophy of agency							
Skill training in specific treatment methodologies							
Discipline policy including passive restraint							
P&P on evaluation and documentation requirements							
Identification and reporting of child abuse and neglect							
Confidentiality of Records							
Crisis intervention							
grief and loss							
Child development							
Universal precautions							
30 hours annually							
Direct Care Staff Only -Children							
Child abuse and Neglect identification and reporting							
Approved forms of discipline							
Infection Control/Blood							

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Borne Pathogens						
Parenting Issues, collaboration with families, and supporting children and families in making choices						
Psychosocial and emotional needs of children , family relationships, and impact of separation						
Special Needs of the population						
Child Development						
The role of the child care employee						
Food Preparation, food service, and nutrition						
Communication skills						
Total 40 Hours per year						
Medication Administration/Delegation (if applicable)						
Med Certified						

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Treatment Foster Care 07.05.02. 18, 07.02.21.05 & 07.02.21.07						
Licensee:						
	Foster Parent Name	Position			Initials	
1						
2						
3						
4						
5						
Foster Parent Files		Staff # 1	Staff # 2	Staff # 3	Staff # 4	Staff # 5
TB every two years						
Medical exam						
Face Sheet Name, address, Telephone number, other members name and relationship						
Application and references						
Agencies home study						
Agencies findings						
Marital StatusRecord of each placement						
Documentation of Agencies monitoring Annual recertification						
Criminal background						
Child abuse and support clearances						
Trainings						
Fire and Health inspections						
Trainings 07.05.02.12						
Role and Relationship in foster care between agency foster parent and child						
Separation anxiety importance of parents and siblings						
Developmental needs						
Care of special needs						
Cultural and religious awareness						
Child management and discipline						
Child abuse and neglect						
Support services in community						
Self-awareness						

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Communication					
Problem solving					
First aid and home safety					
Human sexuality					
Foster care as prep for adoption					
Need for adoption					
Adoption responsibilities					
Function of CRBC					
Legal technical and financial educational aspects					
Nature and purpose of agency documents					
Treatment Foster Parent Trainings	# 1	# 2	# 3	# 4	# 5
24 hours pre-service training					
Importance of Foster parents					
Definition of foster care and its relationship to permanency planning					
Rationale for teamwork in permanency planning					
Explanation of needs and rights of children					
Needs rights and responsibilities of parents					
Roles of foster parents and caseworkers					
Grieving process					
Feelings about separation					
Working with behaviors of child					
Development of accepting attitude					
Issues of substance abuse					
Universal precautions					
20 hours annually					
Crisis recognition, management and intervention					

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**Physical Plant Inspection
Alternative and Preventative
*Highlighted are For Children Only***

RCS Program		Date:	
Approved By Residential Specialist (Adults Only)		Time:	
Building and Grounds 14.31.06.07			
Free from trash and debris/ Trash cans w/lids			
Playground equipment safe			
Yard maintained in good condition			
Comments:			
Emergency			
First Aid Kit			
Evacuation plans (each floor)			
Smoke alarms(each floor)			
Fire extinguishers(each floor)			
Emergency numbers by all phones			
Hallways/Stairways			
Free from Obstruction			
Adequate Light14.31.06.06 K 2			
Comments:			
Living Area			
Walls clean free from cracks and perforations			
Clean and orderly			
Adequate Light14.31.06.06 K 2			
Free from Hazards			
Furniture in good repair 14.31.06.07 I			
Comments:			
Kitchen and Dinning Area14.31.06.07			
Adequate Light 14.31.06.06 K 2			
Sufficient equipment (silverware, cups)			
1 week supply of food 14.31.06.10.B2			
Menu Available			

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Equipment in working order				
Disposable dinnerware (prohibited unless documented)				
Dishes, cups free from chips and cracks				
Adequate seating area				
Water temperature 110°				
Comments:				
Doors and Windows 14.31.06.07				
Screens				
Window coverings				
Doors in good condition				
Windows open and close 14.31.06.07M1				
Comments:				
Sleeping Accommodations 14.31.06.07				
Initials of Residents assigned to room				
1		3		
2		4		
	Room 1	Room 2	Room 3	Room 4
Bed, dresser, tables, chairs in good condition				
Bedroom Clean and orderly				
Source of Natural Lighting				
Adequate Light 14.31.06.06 K 2				
Adequate storage				
Adequate clean and comfortable clothing 14.31.06.10 D				
Comments:				
Room 1				
Room 2				
Room 3				
Room 4				

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Bathrooms	Location of		
Bathroom 1			
Bathroom 2			
Bathroom 3			
	Bathroom 1	Bathroom 2	Bathroom 3
Clean (Free from Mold)			
Adequate light14.31.06.06 K 2			
Operating condition (toilet, Shower)			
Soap, Shampoo, Paper Towels			
Comments:			
Room 1			
Room 2			
Room 3			
Room 4			
Basement/Washer and Dryer			
Clean and Orderly			
Free from Trash			
Washer and dryer is working order			
Lint trap free from lint			
Basement free from water			
Adequate Light14.31.06.06 K 2			
Comments:			

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Name of Program: _____

Clients Name: _____

1. How long have you been in this program? _____
2. Are you allowed to have visitors? **YES or NO**
 - a. How Often? _____
3. Are you allowed to send or receive mail? **YES or NO**
4. Are you allowed to keep money? **YES or NO**
 - a. If so how much? _____
5. How often do you have fire drills?
a. Weekly Monthly Other _____
6. Do you have a copy of your treatment goals? **YES or NO**
 - a. Do you know you treatment goals? **YES or NO**
7. Do you receive group therapy **YES or NO**
 - a. How Often? _____
8. Do you receive individual Therapy **YES or NO**
 - a. How Often? _____
9. Do you receive Family Therapy **YES or NO**
 - a. How Often? _____
10. Does this program require you to attend school every day? **YES or NO**
 - a. What time do you leave for school? _____
 - b. What time do you get home from school? _____
 - c. Do you receive a report card? **YES or NO** _____
 - d. What are your academic goals(diploma/GED)? _____
 - e. If you miss school what do you do? _____
11. Are you provided with work experience? **YES or NO**
 - a. What type of work experience? _____
 - b. Does it interfere with school? _____
12. What time do you go to bed during Monday through Friday? _____
 - a. Saturday and Sunday? _____
13. What time do you wake up during Monday through Friday? _____
 - a. Saturday and Sunday? _____
14. Is staff awake through out the night? **YES or NO**

15. How do you request a doctor's visit?

16. How long does it take for you to see a doctor when you are sick?

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- a. 15 – 30 minutes b. 1 - 2 hours c. 1 - 5 Days d. 5 - 7 Days

16. Do you get along with your staff? **YES or NO**

17. Do you get along with your peers? **YES or NO**

18. Do you feel safe at this program? **YES or NO** _____

19. Do you wear seatbelts when driving in the company vehicles? **YES or NO**

20. Do you know the Daily Routine of this program?

21. How many meals do you get a day? _____

a. Snacks? _____

b. Do you get enough to eat? _____

22. Does your staff eat with you? **YES or NO**

23. Do you have enough clean, comfortable and well fitted clothing? **YES or NO**

a. Coats **YES or NO**

b. Shoes **YES or NO**

c. Do you help select your clothing **YES or NO**

24. Is there a safe place for you to keep your personal belongings? **YES or NO**

a. Is it locked? **YES or NO**

25. Does this program provide you with sheets, blankets, pillows, wash cloths, towels, combs, toothbrushes, toothpaste, soap? **YES or NO**

26. How often do you go on community activities? _____

a. Library? _____

b. Community centers? _____

c. Plays? _____

d. Museums? _____

e. Do you enjoy these activities? **YES or NO**

27. What types of activities do you enjoy here on grounds _____

28. Does this program Teach you:

a. Personal Hygiene **YES or NO** Community Resources **YES or NO**
Conflict Resolution **YES or NO** Decision Making **YES or NO**

Money Management **YES or NO** Nutrition **YES or NO**

Personal Safety **YES or NO** Peer Relationships **YES or NO**

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Time Management **YES or NO** Dating Marriage and Family
Planning

YES or NO

29. Have you ever been placed in isolation or room restriction? **YES or NO**
a. If so, were you offered prompt access to the bathroom, meals and snacks **YES or NO**
b. Did staff check on you every ten minutes? **YES or NO**
30. Have you ever been placed in a restraint? **YES or NO**
a. If so, what type? _____
b. How Long? _____
c. How many times? _____
d. Why? _____

31. What forms of discipline are used at this program? _____

32. Are you allowed to participate in religious activities? **YES or NO**

33. Is this program sensitive to your background, family and community? **YES or NO**

Comments: _____

