COMMUNITY VOCATIONAL / HABILITATION SURVEY

State Form 51680 (R / 3-06) / BQIS 0004
BUREAU OF QUALITY IMPROVEMENT SERVICES

Name of provider agency		
Address (*number and street, city, state, and ZIP code*)		
Name of contact	Telephone number ( )	E-mail address
Name of individual whose services are being surveyed		Social Security number
Date(s) of survey start (*month, day, year*)	Date(s) of survey end (*month, day, year*)	Time spent (*hours:minutes*)

Setting

☐ Waiver 24 / 7 staffing ☐ Waiver less than 24 / 7 staffing ☐ Waiver residing with family ☐ State line item only ☐ Foster care adult / child ☐ Title XX

Type of waiver (*if any*) ☐ None ☐ Autism waiver ☐ DD waiver ☐ Support Services waiver	Date of most recent plan of care (*month, day, year; attach copy*)
Name of BDDS service coordinator	District number
Lead monitor / quality coordinator	Second quality monitor

The lead quality coordinator is responsible for data entry, filing of incident reports and follow up scheduling of this report.

Upon arriving at the provider, identify yourself as an employee with the Bureau of Quality Improvement Services (provide identification card if requested) and state your purpose for visiting (i.e. to perform an annual provider survey for the Bureau of Quality Improvement Services).

Note any problems with being allowed into the home and notify supervisor before the end of the same business day. If there were no problems, enter N/A.

NAMES & POSITIONS OF STAFF MEMBERS PRESENT

NAME	POSITION	NAME	POSITION

Is staffing correct at time of survey? (*Inquire if all staff scheduled are present.*)

☐ Yes ☐ No

COMMUNICATION WITH THE INDIVIDUAL

Communicate with the individual whenever possible. If the individual is non-communicative, indicate the person acting as their respondent.

Respondent

☐ Self ☐ Family member ☐ Guardian ☐ Paid caregiver ☐ Other (*specify relationship to individual*) _____

REVIEW OF PAPERWORK / DOCUMENTATION		
1. Is the provider accredited by one or more of organizations listed? 460 IAC 6-5-6(2)	1a. ☐ Yes ☐ No ☐ N/A 1b. ☐ Yes ☐ No ☐ N/A 1c. ☐ Yes ☐ No ☐ N/A 1d. ☐ Yes ☐ No ☐ N/A 1e. ☐ Yes ☐ No ☐ N/A	1a. The Commission on Accreditation of Rehabilitation Facilities or its successor 1b. The Council on Quality and Leadership in Supports for People with Disabilities or its successor 1c. The Joint Commission on Accreditation of Healthcare Organizations or its successor 1d. The National commission on Quality Assurance or its successor 1e. An independent national accreditation organization approved by the secretary
2. Current ISP for the individual is present. 460 IAC 6-10-7(a), 6-17-3(b)(7)	☐ Yes ☐ No ☐ N/A	Note any concerns
3. Provider has implemented the medication administration system for the individual. 460 IAC 6-10-7(c), 6-25-4	☐ Yes ☐ No ☐ N/A	Note any concerns
4. Provider has implemented the seizure management system for the individual. 460 IAC 6-10-7(d), 6-25-7	☐ Yes ☐ No ☐ N/A	Note any concerns
5. Provider has implemented the health-related incident management system for the individual. 460 IAC 6-10-7(e), 6-25-9	☐ Yes ☐ No ☐ N/A	Note any concerns
6. Provider has implemented the behavioral support plan for the individual. 460 IAC 6-10-7(f)	☐ Yes ☐ No ☐ N/A	Note any concerns
7. Provider has implemented the specialized diet program for the individual. 460 IAC 6-10-7(a), 6-26-1(d)	☐ Yes ☐ No ☐ N/A	Note any concerns
8. Documentation of service provision. 460 IAC 6-17-3. September 15, 2005 letter to providers signed by Peter Bisbecos	☐ Yes ☐ No ☐ N/A	Note any concerns
9. Is the documentation and environment free of any evidence that a reportable incident may not have been reported? 460 IAC 6-9-5	☐ Yes ☐ No ☐ N/A	Note any concerns
10. Documentation of ISP outcome-related progress. 460 IAC 6-17-3(b)(17). September 15, 2005 letter to providers signed by Peter Bisbecos	☐ Yes ☐ No ☐ N/A	Note any concerns

INDIVIDUAL INTERVIEW SECTION		
11. Do staff treat you with respect, protect your individual rights, and provide you choices? 460 IAC 6-8-2, 6-8-3	☐ Yes ☐ No ☐ N/A	Note any concerns
12. **This question is not to be asked in the presence of provider (*ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE*)** Are you satisfied with your providers? Do the people who help you treat you the way you want to be treated? 460 IAC 6-8-2, 6-8-3	☐ Yes ☐ No ☐ N/A	Note any concerns

NOTE: For safety items, if the individual is non-communicative make a note to that effect and mark "N/A".		**WAS RESPONSE SATISFACTORY?**
13. "What do you do if there is a fire?" 460 IAC 6-29-6, 6-29-7	Document response	☐ Yes ☐ No ☐ N/A
14. "What do you do if there is a tornado warning?" 460 IAC 6-29-6, 6-29-7	Document response	☐ Yes ☐ No ☐ N/A
15. "What do you do if you smell gas?" 460 IAC 6-29-6, 6-29-7	Document response	☐ Yes ☐ No ☐ N/A
16. "What plans or activities does the staff help you with? What training do you receive, what skills have you learned, do you get to make choices and be independent?" 460 IAC 6-24-1, 6-24-2	List activities provided in response	Did reply match satisfactorily with ISP and records? If not, list differences / concerns ☐ Yes ☐ No ☐ N/A

SAFETY & ENVIRONMENTAL REQUIREMENTS		
17. Is this provider's physical facility's interior and exterior free of any health and safety concerns (real risks for injury, infection, disease, etc.)? 460 IAC 6-29-2	☐ Yes ☐ No ☐ N/A	Note any concerns

STAFF INTERVIEW SECTION					
				Record specifics of staff response. "YES" marked for competent, correct responses	**Note any concerns**
18. "Do you know what universal precautions are? Please tell me how you utilize them on the job". (i.e. – what steps do you take if you need to clean up blood)? 460 IAC 6-14-4 (c)(5)	☐ Yes	☐ No	☐ N/A		
19. "Are you familiar with the signs and symptoms of seizure activity, including any aura prior to a seizure? What are they?" 460 IAC 6-14-4(c)(6)(A)	☐ Yes	☐ No	☐ N/A		
20. "How would you document a seizure?" Ask specifically and view the documentation to assure that documentation includes activity before, during and after the seizure. 460 IAC 6-25-7(c)(2)	☐ Yes	☐ No	☐ N/A		
21. Do you know the individual's diet needs, including how to prepare their food? Please tell me about the individual's diet needs." 460 IAC 6-14-4(c)(6)(D&E)	☐ Yes	☐ No	☐ N/A		
22. "Do you know how to report an incident per the BDDS incident reporting procedure?" (Includes knowing the types of reportable incidents and knowledge that they have the ability to independently report incidents to APS/CPS.) 460 IAC 6-9-5	☐ Yes	☐ No	☐ N/A		
23. "Are you aware of possible side effects of the individual's medication? What are they?" 460 IAC 6-14-4(c)(6)(C), 6-25-6	☐ Yes	☐ No	☐ N/A		
24. "Have you been trained in the individual's behavior management plan? What are the targeted behaviors and interventions used?" 460 IAC 6-14-4(c)(6)(B), 6-18-2(g)(1)	☐ Yes	☐ No	☐ N/A		
25. "If manual restraints are used, have you had training in non-injurious aggression management techniques?" 460 IAC 6-18-3	☐ Yes	☐ No	☐ N/A		

STAFF INTERVIEW SECTION (*continued*)		
NOTE: Staff should be able to state how to exit/take shelter, along with precautions to take and whom to contact.		**COMPETENT RESPONSE?**
26. "What do you do if there is a fire?" 460 IAC 6-14-4(7), 6-29-6, 6-29-7	Document response	☐ Yes ☐ No ☐ N/A
27. "What do you do if there is a tornado warning?" 460 IAC 6-14-4(7), 6-29-6, 6-29-7	Document response	☐ Yes ☐ No ☐ N/A
28. "What do you do if you smell gas?" 460 IAC 6-14-4(7), 6-29-6	Document response	☐ Yes ☐ No ☐ N/A

QUESTIONS IN THIS SECTION ARE ADDRESSED TO AND SHOULD BE ANSWERED BY THE BQIS STAFF PERSON PERFORMING THIS SURVEY		
29. Is this visit and survey free of any observed reportable incident, or evidence of a reportable incident? 460 IAC 6-9-5	☐ Yes ☐ No ☐ N/A	If "NO", file an incident report. Make decision on need to implement the BQIS IMINENT DANGER POLICY based on facts. Contact supervisor and provide update on filing of incident report, any other policy implementation, and get consensus on appropriate immediate action. Summarize findings and actions taken:
30. Is this visit and survey free of any observed heath or safety concerns for this individual not documented in the questions listed above that DO NOT meet the BDDS Incident Reporting criteria?	☐ Yes ☐ No ☐ N/A	If "NO", describe in detail

NOTES
For additional notes, attach sheets / documents as necessary.

I attest that this survey is an accurate account of findings based on my observations on the date and time indicated.

Signature of lead surveyor	Title	Date (*month, day, year*)