BQIS PRE-TRANSITION QA CHECKLIST

Name of resident:	Name of DDARS representative performing QA checklist (print):
Residential Provider:	Signature of DDARS representative listed above:
Home Address:	Date of visit for transition QA Checklist:
Home phone #:	Name & phone # of Targeted Case Manager (SL) QMRP (SGL):
Setting: SL ☐ SGL☐ Other (describe below):	Name & phone # of Residential Provider contact person:
Date Individual scheduled to move into home:	Date of Support Plan used for this checklist:

NOTE: All questions below are to be scored using the current support plan for the resident:
"Yes" = compliance with plan "NA" = not a need in plan
"**NO HOLD EXIT"** (1 through 21) = exit delayed until compliance is reached. **Compliance must be documented on page 4**
"NO" on items 22 through 29 may or may not result in holding an exit, based on individual needs.
NOTE: All "no" responses must include a narrative explaining the deficit

Item	Support/Service	Yes	NO Hold Exit	NA
1	Home and Community Preference (type and location) met?			
2	Home Adaptations in place? (list mandated adaptations)			
3	Home clean and hygienic?			
4	Safe storage of medications, cleaning supplies, knives and other potential hazards?			
5	House, lot, yard, garage, walkways, driveway etc. free from environmental hazards?			
6	Transportation available to meet all community access needs? (describe transportation plans)			
7	Personal physician identified and appointment scheduled? (enter name, phone # & appointment date/time)			
8	Personal dentist identified and appointment scheduled? (enter name, phone # & appointment date/time)			
9	Behavior Support provider identified? (enter name)			
10	Psychiatrist identified? (enter name)			

Item	Support/Service	Yes	NO Hold Exit	NA
11	Adequate Staff assigned? (describe staffing plans)			
12	Staff received information addressing Individual's medical needs?			
13	Staff received information addressing Individual's dietary/nutritional needs?			
14	Staff received information addressing Individual's personal hygiene needs?			
15	Staff received information addressing Individual's mobility needs?			
16	Staff received information addressing Individual's behavioral considerations?			
17	High Risk issues identified and plans developed to address them? (list individual risk issues)			
18	Phone installed in home? (enter phone #)			
19	Is an emergency telephone list present?			
20	Hot water no warmer than 110º Fahrenheit (or documentation of safeguards in place to ensure that the individual is not at risk for scalding)?			
21	Does the Plan of Care identify and address all necessary services and supports? (Identify Service Coordinator and date discussion held)			
Item	**Support/Service**	**Yes**	**NO**	**NA**
22	Neurologist identified? (enter name)			
23	Other needed medical specialist identified? (enter specialty and name for each, if known)			
24	OT/PT provider identified? (enter name)			
25	Speech/Language Pathologist identified? (enter name)			
26	Dietician identified and a plan in place for meeting nutritional needs? (enter name)			
27	Medical equipment present or arrangements made to obtain equipment? (list all equipment)			
28	Adaptive equipment present or arrangements made to obtain equipment? (list all equipment)			
29	Home stocked with food to accommodate the new occupant?			

List all participants, and titles:

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Notes:

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CORRECTIVE ACTION RESPONSES FOR DEFICIENCIES NOTED

Item #	Detailed explanation of deficit	Corrective Action Plan (includes specific actions planned; names of people contacted and dates/times of contact; targeted date for completion	Target Date for Action	Entity Responsible for Action	Date resolved	Resolution verified by: