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**Board and Care Visitation Checklist**

**Board and Care Name:**

**Address: Phone:**

**Name of Operator:**

**Visit Date: Reviewer(s):**

**Licensed: Yes: No: # of Beds: \_\_\_\_\_\_ # of Current Residents:**

**Monthly Rent: # of Male Residents: \_\_ # of Female Residents:**

**Resident Networks: CODAC: \_ COPE: La Frontera Other:**

**I. Visual Observation - Describe facility:**

**II. Information Obtained from Operator:**

**a. How do residents find out about your facility?**

**b. How are meals provided?**

**c. Describe contact with residents' case managers and/or providers.**

|  |  |  |
| --- | --- | --- |
| **Questions:** | **Yes** | **No** |
| **1. Do you store resident's medication?** |  |  |
| **2. Do you remind residents to take medications?** |  |  |
| **3. Do you read the medication label to the resident to ensure that resident patient is taking it correctly and/or to reassure resident that they are taking correct dosage?** |  |  |
| **4. Do you open the medication for the resident?** |  |  |
| **5. Do you distribute/pour out medications for residents?** |  |  |
| **6. Do you observe resident to make sure medications are taken?** |  |  |
| **7. Do you have a key to the locked medication?** |  |  |
| **8. Is unit furnished or unfurnished?** |  |  |
| **9. Is there any pest control program?** |  |  |
| **10. What time are meals served? Breakfast: Lunch: Dinner:**  |  |  |
| **Questions:** |  |  |
| **11. Are clients allowed seconds?** |  |  |
| **12. Are there any snacks available to clients?** |  |  |
| **13. Any means for clients to store snacks in their rooms, or access to snacks between meals?** |  |  |
| **14. Are evacuation routes clearly posted?** |  |  |
| **15. Are there fire and smoke alarms?**  |  |  |
| **16. Are fire and smoke alarms working?** |  |  |
| **17. How did the client end up at the board and care? Did their service provider recommend this location?** |  |  |
| **18. Which service provider?**  |  |  |
| **19. Does the board and care maintain any kind of file or emergency information on the clients?** |  |  |
| **20. Number of staff on duty during each shift?** |  |  |
| **21. Is training provided for staff? If yes, describe:** |  |  |
| **22. Are emergency phone numbers posted?** |  |  |
| **23. Are clients rights posted?** |  |  |
| **24. Is there a curfew?** |  |  |
| **25. Are there clean and functional laundry facilities on the premises?** |  |  |
| **26. Are there any disciplinary procedures in place?** |  |  |
| **27. Are activities provided for the clients? Describe:** |  |  |
|  |  |  |
|  |  |  |

**III. Information Obtained from Residents**

|  |  |  |  |
| --- | --- | --- | --- |
| **Person expressed satisfaction concerning:** | **Person 1** |  **Person 2** |  **Person 3** |
|  |  **Yes** |  **No** |  **Yes** |  **No** |  **Yes** |  **No** |
| **28. Meals?** |  |  |  |  |  |  |
| **29. Feeling safe?** |  |  |  |  |  |  |
| **30. Rules of facility?** |  |  |  |  |  |  |
| **31. Money management?** |  |  |  |  |  |  |
| **32. Treatment by staff?** |  |  |  |  |  |  |
| **33. Treatment by other residents?** |  |  |  |  |  |  |
| **34. Living conditions (adequate bedding, hot water, temperature?** |  |  |  |  |  |  |
| **35. Daily activities?** |  |  |  |  |  |  |
| **36. Access to money?** |  |  |  |  |  |  |
| **37. Transportation?** |  |  |  |  |  |  |
| **38. Privacy?** |  |  |  |  |  |  |
| **40. Enjoyment of life in general?** |  |  |  |  |  |  |
| **41. Living somewhere else?** |  |  |  |  |  |  |
| **42. Person using adaptive devices? (walkers, wheelchair, glasses, etc.)** |  |  |  |  |  |  |
| **43. Contact with case manager?** |  |  |  |  |  |  |
| **44. Do you have a current ISP or treatment plan?** |  |  |  |  |  |  |
| **45. Did reviewer find evidence that conflicted with person's statement?** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Questions:** |  **Yes** |  **No** |  **Yes** |  **No** |  **Yes** |  **No** |
| **46. Do you store your own medications?** |  |  |  |  |  |  |
| **47. Are you reminded to take medications?** |  |  |  |  |  |  |
| **48. Are medication labels read to you?** |  |  |  |  |  |  |
| **49. Do you pour your own medications?** |  |  |  |  |  |  |
| **50. Does the staff watch you take your medication?** |  |  |  |  |  |  |
| **51. Are medications kept in locked places (rooms/boxes)?** |  |  |  |  |  |  |
| **52. Does staff have a key to your unit?** |  |  |  |  |  |  |
| **53. Do you have a key to your unit?** |  |  |  |  |  |  |
| **54.** |  |  |  |  |  |  |

**IV, Concerns of Reviewer(s) (If yes, describe below)**

**Are there any identifications of abuse? Yes No**

**(residents hurting each other; harmed by staff; inappropriate grouping of people?**

**Are there any staffing issues? Yes No**

**(respectful to/by staff; residents treated as individuals)**

**Are there any boarding home safety and/or living issues? Yes No**

**Are there any evidence of substantial medication problems? Yes No**

**Are there any issues with furniture? Yes No**

**Are there any issues with the units NOT cleaned or maintained? Yes No**

**Are there any food storage/spoilage problems? Yes No**

**Are there violation of individual's rights? Yes No**

**(no use of phone, no visitors, censorship of mail, lack of**

**freedom of movement)**

**Revised 3/18**