SURVEY OF RESIDENTIAL SERVICES AND SUPPORTS

State Form 51679 (R / 3-06) / BQIS 0003

INSTRUCTIONS: Prepare data in the ISP and Behavioral Support Plan Review sections prior to arrival at residence.

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*)
Address of home (*number and street, city, state, and ZIP code*)		
Setting ☐ Waiver 24 / 7 staffing ☐ Waiver less than 24 / 7 staffing ☐ Waiver residing with family ☐ State line item only ☐ Foster care adult / child		
Name of guardian		
Address of guardian (*number and street, city, state, and ZIP code*)		
Type of waiver (*if any*) ☐ None ☐ Autism waiver ☐ DD waiver ☐ Support Services waiver		Date(s) of most recent plan of care (*month, day, year; attach copy*)

PROVIDERS LISTED ON PLAN OF CARE / ISP

NAME OF PROVIDER	PROVIDER CONTACT INFORMATION	SERVICES AUTHORIZED ON PLAN OF CARE / ICLB	CONFIRMED WITH CM?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Name of BDDS service coordinator	District number

Review incident report database

Have any incidents been reported for this individual in the past year? ☐ Yes ☐ No *If yes, note concerns in file.*

Review complaint database

Have any complaints been reported for this individual in the past year? ☐ Yes ☐ No *If yes, note concerns in file.*

Review targeted case manager 90-day review for past 12 months. Note any problems.

Lead quality coordinator	Second quality monitor / coordinator

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

Upon arriving at the home, 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). The individual or legal representative has the right to refuse entry into the home.

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 home 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*) _____

INDIVIDUALIZED SUPPORT PLAN (ISP) REVIEW		
1. Individual's ISP developed as outlined in 460 IAC and is current. 460 IAC 7-4-1; 7-4-5(1)(2)	☐ Yes ☐ No	Note any concerns
2. PCP directed by facilitator who has completed training by an approved BDDS entity. 460 IAC 7-4-1	☐ Yes ☐ No ☐ N/A	Note any concerns
3. Personal and demographical information included in the ISP. 460 IAC 7-5-2	☐ Yes ☐ No ☐ N/A	Note any concerns
4. Emergency contacts completed. 460 IAC 7-5-4	☐ Yes ☐ No ☐ N/A	Note any concerns
5. The Person Centered Planning profile is available for review and indicates person centered planning process used. 460 IAC 7-3-12; 7-3-13; 7-4-1	☐ Yes ☐ No ☐ N/A	Note any concerns
6. Desired outcomes are individualized and based on a person centered planning process. 460 IAC 7-3-12; 7-4-1, 7-5-1.	☐ Yes ☐ No ☐ N/A	Note any concerns
7. Proposed strategies/activities are individually developed and directly related to desired outcomes. 460 IAC 7-5-5. September 15, 2005 letter to providers signed by Peter Bisbecos.	☐ Yes ☐ No ☐ N/A	Note any concerns
8. Responsible party identified for each proposed strategy/activity. 460 IAC 7-5-5(b)(5)	☐ Yes ☐ No ☐ N/A	Note any concerns
9. Time frame of less than 12 months for each proposed strategy/activity. 460 IAC 7-5-5(b)(6)	☐ Yes ☐ No ☐ N/A	Note any concerns
10. Statement of agreement signed and dated by individual. 460 IAC 7-5-6	☐ Yes ☐ No ☐ N/A	Note any concerns
11. The ISP lists each person participating in the development of the ISP, their relationship to the individual, the date the ISP was forwarded to each participant and the method by which it was forwarded to each participant. 460 IAC 7-5-7	☐ Yes ☐ No ☐ N/A	Note any concerns

BEHAVIORAL SUPPORT PLAN (BSP) REVIEW						
Does individual have Behavioral Support services provider designated in ISP or have a Behavior Support plan? **If NO, go to the "Individual Interview" section.**					☐ **Yes**	☐ **No**
If YES, review the following areas:					**CONFIRMED BY ON-SITE SURVEY?**	
12. BSP defines target behaviors. 460 IAC 6-18-2(b)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A
13. BSP based on functional analysis or functional assessment. 460 IAC 6-18-2(c)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A
14. BSP contains written guidelines for teaching functional and useful replacement behaviors. 460 IAC 6-18-2(d)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A
15. BSP uses non-aversive methods for teaching functional and useful replacement behaviors. 460 IAC 6-18-2(e)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A
16. BSP conforms to ISP, including needs and outcomes identified in the ISP and the ISP's specifications for behavioral support services. 460 IAC 6-18-2(f)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A
17. BSP includes a documentation system for direct care staff including all elements noted in 460 IAC 6-18-2(h)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A
18. If the BSP includes the use of medication to assist with the management of behavior, the BSP includes a method for assessing the use of medication and the appropriateness of a medication reduction plan or documentation that a medication reduction plan was implemented in the past five years and found to be ineffective. 460 IAC 6-18-2(i)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes	☐ No	☐ N/A

BEHAVIORAL SUPPORT PLAN (BSP) REVIEW - RESTRICTIVE PROCEDURES

The following six items apply if a highly restrictive procedure (including medication or physical restraint) is used as part of the BSP. Highly restrictive procedures may broadly be considered those that restrict rights or access in any way(barriers, locks, alarms, restrictions to personal items, punishments), that involve reactive procedures(restraints, holds, escorts), and/or the use of psychotropic medications.

Does Behavior Support Plan include any highly restrictive procedures? **If NO, go to the "Individual Interview" section.**				☐ **Yes** ☐ **No**
If YES, review the following:				**CONFIRMED BY ON-SITE SURVEY?**
19. Documentation that the BSP is reviewed regularly by the individual's support team. 460 IAC 6-18-2(j)6	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes ☐ No ☐ N/A
Does the plan contain:				**CONFIRMED BY ON-SITE SURVEY?**
20. Functional analysis of targeted behavior, if a highly restrictive procedure is used to manage behaviors. 460 IAC 6-18-2(j)1, 6-18-3(1)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes ☐ No ☐ N/A
21. Documentation that the risks of targeted behavior have been weighed against the risks of a highly restrictive procedure (medication or physical restraint). 460 IAC 6-18-2(j)(2)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes ☐ No ☐ N/A
22. Documentation that systemic efforts to replace targeted behavior with an adaptive skill were used and found to be ineffective. 460 IAC 6-18-2(j)(3)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes ☐ No ☐ N/A
23. Documentation that the individual, the individual's support team and the applicable human rights committee agree that the use of the highly restrictive procedure is required to prevent significant harm to the individual or others. 460 IAC 6-18-2(j)(4)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes ☐ No ☐ N/A
24. Informed consent from the individual or the individual's legal representative. 460 IAC 6-18-2(j)(5)	☐ Yes	☐ No	☐ N/A	Note any concerns	☐ Yes ☐ No ☐ N/A

INDIVIDUAL INTERVIEW SECTION - INDIVIDUAL RIGHTS / RESPECT IAC 6-8-2, IAC6-8-3, IAC 6-9-3				
25. Staff treat individual with respect and solicit his/her input when appropriate. 460 IAC 6-8-2 & 6-8-3.	☐ Yes	☐ No	☐ N/A	Note any concerns. Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
26. Individual is given choices on activities. 460 IAC 6-8-2, 6-8-3.	☐ Yes	☐ No	☐ N/A	Note any concerns. Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
27. Individual has access to personal possessions when staff is present. 460 IAC 6-8-2, 6-8-3.	☐ Yes	☐ No	☐ N/A	Note any concerns. Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
28. Individual has adequate privacy in bedroom and bathroom when staff is present. 460 IAC 6-8-2, 6-8-3.	☐ Yes	☐ No	☐ N/A	Note any concerns. Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
29. (***ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE***) Individual is satisfied with how his/her money is being handled, how financial issues are being addressed and receives copies of the balanced checkbook monthly. 460 IAC 6-8-2, 6-8-3, 6-24-3	☐ Yes	☐ No	☐ N/A	Note any concerns. See interpretive guidelines on how to proceed if "No".
30. **This question is not to be asked in the presence of provider. (*ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE*)** Individual is satisfied with his/her providers and is being treated the way he or she wants to be treated. 460 IAC 6-8-2, 6-8-3	☐ Yes	☐ No	☐ N/A	Note any concerns. Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
31. **This question is not to be asked in presence of TCM. (*ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE*)** Individual is satisfied with his/her case manager and the case manager is doing things the way the individual thinks they should be done. 460 IAC 6-19-6	☐ Yes	☐ No	☐ N/A	Note any concerns. Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
32. Individual knows who his/her case manager is. 460 IAC 6-19-6	☐ Yes	☐ No	☐ N/A	Do not cite for "No", but forward concerns to CM or BDDS SC if no CM.
33. Case manager has seen or talked to the individual in the past 90 days. 460 IAC 6-19-6, 6-19-7(2)(c)	☐ Yes	☐ No	☐ N/A	Confirm documentation of TCM presence in home and note.

NOTE: For the safety items, if the individual is non-communicative, make a note to that effect and mark "N/A". (***Caretaker will be questioned later in the survey regarding these safety issues.***)		**WAS RESPONSE SATISFACTORY?**		
34. Individual knows what to do in case of fire. 460 IAC 6-29-6, 6-29-7	Document response	☐ Yes	☐ No	☐ N/A
35. Individual knows what to do in case of a tornado. 460 IAC 6-29-6, 6-29-7.	Document response	☐ Yes	☐ No	☐ N/A
36. Individual knows what to do if he/she smells gas. 460 IAC 6-29-6, 6-29-7.	Document response	☐ Yes	☐ No	☐ N/A
37. This item is not currently used.				

HEALTH CARE COORDINATION, BY PROVIDER		
Is there a provider identified as responsible for Health Care Coordination in the ISP?	☐ **Yes** ☐ **No**	Who is responsible for HCC? (*"Self," or name of family-member / provider*)
NOTE: IF INDIVIDUAL OR FAMILY MEMBER IS RESPONSIBLE FOR HCC, THEN GO TO "HEALTH CARE COORDINATION, Non-Provider" (6-25-1)		

38. This item is not currently used.			
39. This item is not currently used.			
40. Individual received adequate and immediate treatment for any medical emergencies in the past year. 460 IAC 6-25-2, 6-25-3, 6-17-3	☐ Yes - had correct ER treatment ☐ No - ER treatment was NOT correct ☐ N/A - no medical emergencies	List all concerns	
41. Individual received proper follow up care as prescribed by the physician. 460 IAC 6-25-2, 6-25-3	☐ Yes - had proper follow-up ☐ No - did NOT receive needed follow-up ☐ N/A - no ER treatment	List all concerns	
42. This item is not currently used.			
43. This item is not currently used.			
44. All medical conditions monitored and followed up on as recommended or prescribed by physician. 460 IAC 6-25-3	☐ Yes ☐ No ☐ N/A	List all concerns	
45. This item not currently used.			
46. Medication needs addressed by the ISP. 460 IAC 6-25-3, 6-25-4.	☐ Self - self medicates ☐ Other - someone else medicates ☐ N/A - no medication	List all concerns	Agrees with ISP? ☐ Yes ☐ No ☐ N/A
47. Medication by someone other than the individual is properly documented. 460 IAC 6-25-4, 6-25-5, 6-25-6	☐ Yes - documentation in order ☐ No - problems with documentation ☐ N/A - self-administer or no medication	List all concerns	
48. This item not currently used			

HEALTH CARE COORDINATION, BY PROVIDER (SEIZURES)		
Do you have a history of seizures? **If NO, go to "Safety and Environmental" section.**	☐ **Yes** ☐ **No**	List any concerns
49. This item not currently used.		
50. Individual requires services to manage a seizure disorder. 460 IAC 6-25-3, 6-25-4	☐ Yes ☐ No ☐ N/A	
Items 51-55 apply to the seizure management system as required by the individual's ISP. (6-25-7)		
51. Seizure management system includes staff training on medication administration. 460 IAC 6-25-7	☐ Yes ☐ No ☐ N/A	
52. Seizure management system includes a seizure tracking system to document events immediately preceding, during, and following a seizure. 460 IAC 6-25-7	☐ Yes ☐ No ☐ N/A	
53. This item not currently used.		
54. Individual's level of seizure medication checked annually or as ordered by physician. 460 IAC 6-25-7	☐ Yes ☐ No ☐ N/A	
55. Seizure management system communicated to all providers working with the individual. 460 IAC 6-25-7	☐ Yes ☐ No ☐ N/A	

HEALTH CARE COORDINATION, NON-PROVIDER (INDIVIDUAL OR FAMILY-MEMBER)		
56. IF INDIVIDUAL/FAMILY MEMBER IS RESPONSIBLE FOR HEALTH CARE COORDINATION: Individual is satisfied with how health care needs are being met, receiving adequate support in meeting health care needs, and sharing concerns (*if any*) with case manager.	☐ Yes ☐ No ☐ N/A	Note response

SAFETY & ENVIRONMENTAL REQUIREMENTS

Request permission from individual before touring the residence. Best practice is the individual providing a tour of the home to assess the environment for health and welfare issues.

Use these guidelines to review the interior and exterior of the home:

- Cleanliness of area related to risk of infection/disease
- Cleaning and food items are stored properly
- Minimal use of extension cords
- No window coverings that pose a danger to the individual (ex - cords from blinds that hang on the bed)
- Free from foul odors, insects and rodents;
- Furnishings meet the needs of the individuals
- No exposed wiring – including absence of outlet covers
- Adequate heating and cooling
- Appliances and fixtures in working order
- No frayed cords; empty light sockets, burned out or bare light bulbs
- General maintenance – home is in good condition – holes patched, etc.

SAFETY & ENVIRONMENT, BY PROVIDER

Is there a provider designated as responsible for providing environmental & living arrangement support in the ISP?	☐ **Yes** ☐ **No**	Who is the responsible party? (*"Self," or name of family-member / provider*)
NOTE: IF THIS IS THE INDIVIDUAL OR FAMILY MEMBER, GO TO THE "Safety & Environment, Non-Provider" section. (6-29-1)		

Review each of the following items:		
57. Home is free from any health and welfare risks. 460 IAC 6-29-2.	☐ Yes ☐ No ☐ N/A	For any "NO" answers, describe specific issues and provide specific details as to why there is a cause for concern.
58. Home is accessible to the individual. 460 IAC 6-8-2	☐ Yes ☐ No ☐ N/A	
59. Emergency and informational phone numbers are visible from the telephone used by the individual or as indicated in the ISP. 460 IAC 6-29-8.	☐ Yes ☐ No ☐ N/A	
60. Food present in the setting is congruent with the individual's diet needs as identified in the ISP. 460 IAC 6-26-1	☐ Yes ☐ No	
61. Medications stored according to requirements or as indicated in the ISP. 460 IAC 6-25-4.	☐ Yes ☐ No	
62. All adaptive equipment identified in the ISP is present and the individual and staff know how to use the equipment. 460 IAC 6-29-3	☐ Yes ☐ No	
NOTE: Test the alarm/s after asking permission to do so. Only the individual or family can deny permission. 63. Working smoke alarm present in areas identified by fire marshal. 460 IAC 6-29-4	☐ Yes ☐ No	
64. Working fire extinguisher present and checked annually. 460 IAC 6-29-4	☐ Yes ☐ No	
65. Tap water at maximum of 110 degrees Fahrenheit or less unless ISP specifies that individual can mix own water independently and this safeguard is not required. 460 IAC 6-29-4	☐ Yes ☐ No	

SAFETY & ENVIRONMENT, NON-PROVIDER (INDIVIDUAL OR FAMILY-MEMBER)

66. All health and welfare issues in home being handled appropriately. 460 IAC 6-29	☐ Yes ☐ No ☐ N/A	Note any concerns: Do not cite for "NO", but forward concerns to CM or BDDS SC if no CM
67. All environmental or living supports in home being handled appropriately. 460 IAC 6-29	☐ Yes ☐ No ☐ N/A	Note response: Do not cite for "NO", but forward concerns to CM or BDDS SC if no CM

REVIEW OF DOCUMENTATION - ISP								
68. Current ISP in the home. 460 IAC 6-17-3(b)(7)	☐ Yes	☐ No	☐ N/A	Date of plan (*month, day, year*)				
69. This item is not currently being used.								

The ISP contains a subsection that outlines the requirements regarding health and behavioral issues. This section is used to indicate if a provider of a service is needed by the individual and identifies the provider of that service or support. In this section of the survey, the ISP is reviewed to determine if identified needs have been properly addressed with the appropriate services and supports and to determine if those services have been implemented in accordance with the ISP. If any item in the Meeting Issues and Requirements section is not identified as a need for the individual, that item will not be surveyed unless there is evidence in the individual's record that the item is an issue that has not been appropriately addressed by the support team (i.e. seizures is not identified in the Meeting Issues section, but there is evidence in the individual's record of a diagnosis of seizure disorder or a history of seizures).

Individualized Support Plan identifies a need for: (#70 – #86 below IAC 7-5-8)	If listed in ISP, does documentation confirm all supports in place?			If not listed in ISP, does documentation confirm it should not be listed?			Describe all "NO" responses from 2nd or 3rd columns
70. ☐ Seizure management	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
71. ☐ Allergies	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
72. ☐ Uses or Requires Dentures	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
73. ☐ Chewing difficulties	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
74. ☐ Swallowing difficulties	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
75. ☐ Dining difficulties	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
76. ☐ Vision difficulties	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
77. ☐ Hearing difficulties	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
78. ☐ Speaking difficulties – mode of communication	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
79. ☐ Behavior issues	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
80. ☐ Issues discovered through incident reporting	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
81. ☐ Medication/self-medication issues	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
82. ☐ Lab testing	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
83. ☐ Chronic conditions	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
84. ☐ Water Temperature Safety	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
85. ☐ Dentist	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
86. ☐ Other Specialists	☐ Yes	☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A	
87. This item is not currently used.							
88. This item is not currently used.							
89. This item is not currently used.							

REVIEW OF DOCUMENTATION - ISP (*continued*)		
90. Individual's personal file contains documentation for the past two months including a description of the individual's residential habilitation supports activities addressing outcomes in the individual's ISP, a summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member. September 15, 2005, letter to providers signed by Peter Bisbecos.	☐ Yes ☐ No ☐ N/A	Note any concerns
91. Documentation and environment free of evidence that a reportable incident may not have been reported. 460 IAC 6-9-5	☐ Yes ☐ No ☐ N/A	If no, provide the details of the reportable incident
92. This item not currently being used.		

STAFF INTERVIEW SECTION				
			Record specifics of staff response. Mark "Yes" only for competent, correct responses.	**Note any concerns**
93. Staff can demonstrate knowledge of Universal Precautions. 460 IAC 6-14-4	☐ Yes	☐ No	☐ N/A	
94. Staff are familiar with the signs and symptoms of seizure activity, including an aura prior to a seizure. 460 IAC 6-14-4	☐ Yes	☐ No	☐ N/A	
95. Staff can demonstrate how they document a seizure. 460 IAC 6-25-7	☐ Yes	☐ No	☐ N/A	
96. Staff can demonstrate knowledge of the individual's dietary needs. 460 IAC 6-14-4	☐ Yes	☐ No	☐ N/A	
97. Staff knows how to report an incident to BDDS and can identify examples of reportable incidents. Staff is aware that they can independently report incidents to APS/CPS. 460 IAC 6-9-5	☐ Yes	☐ No	☐ N/A	
98. Staff are aware of possible side effects of the individual's medication. 460 IAC 6-14-4, 6-25-6	☐ Yes	☐ No	☐ N/A	
99. Staff are trained in the individual's behavioral support plan. 460 IAC 6-14-4, 6-18-2	☐ Yes	☐ No	☐ N/A	
100. Staff have been trained in non-injurious aggression management techniques. 460 IAC 6-18-3	☐ Yes	☐ No	☐ N/A	
101. Staff are aware of what to do in case of fire. 460 IAC 6-14-4(7).	☐ Yes	☐ No	☐ N/A	
102. Staff are aware of what to do in case of a tornado. 460 IAC 6-14-4(7).	☐ Yes	☐ No	☐ N/A	
103. Staff are aware of what to do if they smell natural gas. 460 IAC 6-14-4(7)	☐ Yes	☐ No	☐ N/A	

QUESTIONS IN THIS SECTION ARE ADDRESSED BY THE BQIS STAFF PERSON PERFORMING THIS SURVEY			
104. Visit and survey are free of any observed incidents of or evidence of a reportable incident. 460 IAC 6-9-5	☐ Yes	☐ No	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:
105. Visit and survey are free from any observed health or safety concerns for the individual not addressed in the items listed above that do not meet the BDDS incident reporting criteria.	☐ Yes	☐ No	If "NO", describe in detail

NOTES

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*)