

CCRSS PROVIDER NAME		CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)	

ATTACHMENT H



AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
RESIDENTIAL CARE SERVICES  
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)  
**CCRSS Home Environment and Safety Worksheet**

Observations of the environment occur throughout the certification evaluation process.

CLIENT NAME	CCRSS SAMPLE ID NUMBER
-------------	------------------------

DATE OF OBSERVATIONS	TIME OF OBSERVATIONS
----------------------	----------------------

Quality of Life / Client Rights			WAC 388-101D-0170
Y	N	N/A	Y N N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were staff to client interaction(s) responsive and meeting client needs?			Did staff respect the client's dignity, privacy, and rights?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did staff refrain from speaking over clients or in another language?			Was there accessible telephone equipment and list of emergency contact numbers?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was staff / client communication appropriate?			Were doors and windows unblocked?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was adaptive / life sustaining equipment available, clean, and in good repair?			Was the environment homelike?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there recognition of the client's cultural diversity and preferences?			Were audio monitors used appropriately?

Physical Environment			Y N N/A
Y	N	N/A	Y N N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were stairs / steps, handrails / ramps, and walkways in good repair?			Were flammable and combustible materials stored safely?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear of clutter that could be potentially hazardous to the client(s)?			Was the yard free of garbage / refuse?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear of signs of unsanitary home conditions (i.e., mold, mildew, etc.)?			Was the property free of pests?

Bathrooms			Y N N/A
Y	N	N/A	Y N N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe and clean?			Accessible for all clients?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adequate lighting?			Private?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grab bars?			Other:

Safety			Y N N/A
Y	N	N/A	Y N N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency food and water supply?			Operating smoke detectors (with light alarm for clients with hearing impairments)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications locked-up?			Cleaning supplies / toxic materials locked-up if required by clients' safety needs?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First aid supplies available?			Evacuation plan and practice drills?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working flashlight available?			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Door / window alarms (CP only)?			

Water Temperature in °F, check in two (2) locations (if first check >120°F, re-check water temperature)			
Temperature: _____ °F	<input type="checkbox"/> Kitchen	Temperature: _____ °F	<input type="checkbox"/> Kitchen
Date / time: _____	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Date / time: _____	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Temperature: _____ °F	<input type="checkbox"/> Kitchen	Temperature: _____ °F	<input type="checkbox"/> Kitchen
Date / time: _____	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Date / time: _____	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.