|  CCRSS PROVIDER NAME | CERTIFICATION NUMBER |
| --- | --- |
| RCS CONTRACTED EVALUATOR / STAFF NAME | CERTIFICATION EVALUATION DATE(S) |
|  |
|  |  ATTACHMENT B AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA) RESIDENTIAL CARE SERVICES CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS) **CCRSS Certification Evaluation Client Supports Observation** |
| CLIENT NAME | CLIENT SAMPLE ID NUMBER |
| DATE OF CLIENT OBSERVATIONS (OBSERVATIONS IN CLIENT HOME UNLESS OTHERWISE NOTED) |
| The information listed in the left box of each category is a guideline, document observations in the right box.**If no observation occurred, mark the “Not Observed” box for that section.** |
| **A. Staff / Client Interactions Time of Observation:       [ ]  Not Observed**  |
| What staff instruction and supports were observed?Staff name:  |
| YES | NO | N/A |  | YES | NO | N/A |  |
| [ ]  | [ ]  | [ ]  | Were staff to client interaction(s) responsive and meeting client needs? | [ ]  | [ ]  | [ ]  | Was staff / client communication appropriate? |
| [ ]  | [ ]  | [ ]  | Did staff refrain from speaking over clients or in another language? | [ ]  | [ ]  | [ ]  | Was there recognition of the client’s cultural diversity and preferences? |
| [ ]  | [ ]  | [ ]  | Did staff respect the client’s dignity, privacy, and rights? |  |
| **B. Meals Time of Observation:       [ ]  Not Observed**  |
| What meal(s) were observed? |
| Any dietary restrictions? |
| Did the meal appear balanced and nutritious? |
| Were the restrictions accommodated?[ ]  Yes [ ]  No |
| **C. Medication Assistance Time of Observation:       [ ]  Not Observed**  |
| What kind of assistance did the client require for medications? |
| Who prepared the medications? Preparation includes removing the pills from the bottle / blister pack or bubble.[ ]  Staff [ ]  Client |
| How did the client take their pills? |
| Was the medication mixed in food? (388-101D-0310)[ ]  Yes [ ]  No |
| Was the medication crushed?[ ]  Yes [ ]  No |