

HCBS WAIVERS REPORT OF SUPERVISION – 60 Day Supervisory Visit Report

Provider Name: _____ Date: _____

Client Name _____ County _____

Services Authorized: PC CO SR HM UR SN/RN SN/LPN Worker: Absent Present
Worker Name _____

Purpose of Visit: Initial Visit Complaint Investigation Ongoing Supervision Suspicion of substandard performance

Interview discussion with _____

- Pleased/ Displeased with services Pleased / Displeased with Client/ worker relationship
 Pleased/ Displeased with Worker Pleased/ Displeased with respect demonstrated by worker

1. Is the client area neat and clean? Yes No NA
2. Is the bathroom clean? Yes No NA
3. Is the kitchen clean? Yes No NA
4. Does the home reflect regular cleaning? Yes No NA
5. Is the general appearance of client neat and clean? Yes No NA
6. Is the client odor free? Yes No NA
7. **SR/SN ONLY:** Does the nurse follow current orders? Date of current orders: _____ Yes No NA
8. Does the worker/nurse demonstrate use of infection control/universal precautions? Yes No NA
9. The client/worker/nurse relationship is: Positive/ Needs improvement
10. The client/worker/nurse rapport is: Positive/ Needs improvement
11. Does the worker/nurse report observations/changes to the caregiver and/or agency? Yes No
12. Does the worker/nurse complete documentation while in the client's home? Yes No
13. Does the worker/nurse obtain client/responsible person signature at the end of each visit? Yes No
14. Does the worker/nurse appear neat and clean? Yes No
15. Does the worker/nurse arrive as scheduled? Yes No
16. Does the worker/nurse stay the entire time scheduled? Yes No
17. Does the worker/nurse demonstrate respect for client belongings? Yes No
18. Is there evidence of worker's/nurse's respect for client rights/property? Yes No
19. Does the worker/nurse follow agency policy and procedures? Yes No
20. Does the worker/nurse demonstrate proper body mechanics? Yes No
21. If applicable, supervisor observed the worker/nurse performing the following tasks: _____

22. If applicable, supervisor provided instructions to the worker/nurse regarding the following: _____

23. **Follow Up** is is NOT needed with the worker/nurse, client, family/responsible person, Case Manager
Regarding the following: _____

Client comments/ observations: _____

SUMMARY OF VISIT: (Must answer all questions below)

1. Services are delivered consistent with the plan of care (Provider Authorization)? Yes No
2. Client's needs are being met? Yes No
3. Reference to any complaints lodged? Yes No NA
4. Is there a need for more frequent supervision? Yes No
5. Brief statement regarding changes in service needs:

DSP Supervisor's Printed Name Completing This Form

DSP Supervisor's Signature / Credentials / Date

Client or Responsible Person Signature / Date

Copy sent to HCBS Waiver Case Manager On: _____