



ACF QUALITY CHECKLIST

Instructions: This form is to be completed by the CPST, then reviewed and submitted by the CPST Supervisor.

To be used as a tool for routine monitoring, or as desired to aid in the assessment of resident complaint(s).

Fax or mail completed forms to MHR SB Program Coordinator, 800 Market Avenue North, Suite 1150, Canton, Ohio 44702, (330) 455-7424.

Date & Time _____ ACF Name & Address _____

ACF Staff On-Site _____ Resident(s) _____

Completed By _____ Submitted By _____

Agency _____ Phone _____

Please provide exact details of event(s) being reported. When including personally identifying information, please attach Authorization for Release of Information (for investigative purposes, you may need to include any outside agencies/departments, i.e., Area Agency on Aging Ombudsman & ODH Complaint Hotline).

SCCMHB/ODH/ODMH Standard	Check One		Check One	
	Provided	Not Provided	Reported	Observed
Please provide detail for each item not provided in the space below				
1. Sufficient quantity of food and safe drinking water available at all times				
2. Adherence to special diets				
4. Kitchen kept clean and sanitary (including proper food storage, preparation and distribution)				
5. Laundry service for clothing and linens available or provided weekly (If not on site, staff must make provisions)				
6. Medication stored in a locking compartment at all times				
7. Each level has a working smoke detector, fire extinguisher and emergency evacuation plans				
8. Minimum amount of personal furniture available to each resident (bed, chair, table, dresser) and in good repair				
9. Encouraged recreation and social interaction (reading materials, games, playing cards, activities)				
10. ACF postings: Current State License, SCCMHB Certificate, Resident Rights, Ombudsman Information, House Rules				
11. Trained staff on site 18-23 hours for Level I and 24 hours for Level II				
12. Agency kept apprised of important items needed such as medication and personal items				
14. ACF adheres to requirements of and has on file current Health Assessment, Plan of Care and Residential Agreement				
15. Proper documentation of spending money management				
16. Issue(s) with spending allowance				
17. Adherence to Mental Health Plan for Care				
18. Issue(s) with Residential Agreement				

Additional Concerns/Issues/Comments - Please be detailed and use additional sheets as necessary
