

Resource, Support, Development, Inc.
FIRE EVACUATION DRILL REPORT

LOCATION OF EVACUATION:

Name	Address	City	State

DATE OF EVACUATION:

Month	Day	Year	Time

PLACE INDIVIDUALS WERE EVACUATED TO:

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IF INDIVIDUALS WERE NOT EVACUATED TO A SAFE AREA EXPLAIN WHY:

--

CONSUMER COUNT:

--

 TIME TAKEN TO EVACUATE:

--

WAS THIS AN ACTUAL EMERGENCY: YES NO

IF YES, WHO WAS NOTIFIED:

--

STAFF MEMBERS INVOLVED:

FIRE EXTINGUISHERS MEET THE FOLLOWING 5 POINT CHECK:

- 1. READ GAUGE TO ENSURE CORRECT PRESSURE.
- 2. CHECK TAG FOR EXPIRATION DATE.
- 3. MAKE SURE PIN IS IN PLACE & SECURED WITH STRAP
- 4. TIP EXTINGUISHER OVER & TAP ON THE BOTTOM TO LOOSEN CHEMICAL.
- 5. INITIAL TAG & DOCUMENT THE DATE.

YES NO

FIRE ALARMS TESTED: YES NO

NUMBER:

--

GROUND FAULT CIRCUITS TESTED: YES NO

NUMBER:

--

PROBLEMS IDENTIFIED WITH THE FIRE ALARMS, FIRE EXTINGUISHERS, OR GROUND FAULT CIRCUITS:

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BATTERIES CHANGED ANNUALLY IN FIRE ALARMS: YES NO DATE:

--

CORRECTIVE ACTION NEEDED: YES NO

SIGNATURE OF PERSON COMPLETING THIS REPORT:

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Individual completing this form will type in their name and initial at Admin. Office

TITLE OF PERSON COMPLETING THIS REPORT:

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Resource, Support, Development, Inc
EMERGENCY PROCEDURE DRILL REPORT FORM

LOCATION OF DRILL:

Name	Address	City	State

DATE OF DRILL:

Month	Day	Year	Time

TYPE OF DRILL:

--

PERSON BEING TESTED:

--

WERE CONSUMERS INVOLVED IN THIS EMERGENCY PROCEDURE? YES NO

IDENTIFY AND DEMONSTRATE THE PROCEDURE THE STAFF SHOULD USE IN CASE THE ABOVE LISTED EMERGENCY OCCURRED:

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PROBLEMS IDENTIFIED WITH EMERGENCY DRILL PROCEDURE:

--

WAS THIS AN ACTUAL EMERGENCY? YES NO

IF YES, WHO WAS NOTIFIED?

--

SIGNATURE OF PERSON COMPLETING THIS REPORT:

--

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TITLE OF PERSON COMPLETING THIS REPORT:

--

Resource, Support, Development, Inc.

SAFETY CHECKLIST

Location: []

Address: []

Date: []

ARE THE FOLLOWING ARTICLES POSTED:

- 1. EVACUATION ROUTES IN EACH AREA
2. EVACUATION PROCEDURES
3. INDIVIDUALS STAFF DUTIES FOR EVACUATION
4. FIRE FIGHTING EQUIPMENT LOCATIONS
5. TELEPHONE NUMBERS OF POISON CONTROL, FIRE, AND EMERGENCY MEDICAL SERVICES
6. EXIT LOCATION (MARKED WITH 6" LETTERS) (RESIDENTIAL PROGRAMS OPTIONAL)

Table with 3 columns: YES, NO, N/A. 6 rows for checklist items.

EVACUATION AND FIRE

- 1. FIRE ALARMS TESTED MONTHLY
2. FIRE EXTINGUISHERS MEET CODE AND ARE CHECKED MONTHLY
3. EXITS AND AISLES ARE IN GOOD REPAIR, FREE, AND CLEAR
4. EVACUATION DRILLS ARE HELD
A. MONTHLY
B. DIFFERENT DAYS OF THE WEEK
C. DIFFERENT TIMES OF THE DAY
D. EACH SHIFT OF CORPORATION PERSONNEL
E. TO A SAFE AREA UNLESS DOCUMENTED
F. AND EVACUATION DRILL REPORT HAS BEEN COMPLETED
5. LIGHT BULBS WORK IN EXIT SIGNS

Table with 3 columns: YES, NO, N/A. 11 rows for checklist items.

ALL FLAMMABLE AND COMBUSTIBLE LIQUIDS AND SOLIDS ARE:

- 1. STORED IN APPROVED CONTAINERS
2. STORED IN CLOSED METAL CABINETS
3. LESS THEN 130 DEGREES F.
4. OIL & PAINT SOAKED RAGS, BRUSHES, & FOAM ARTICLES ARE STORED IN AN ENCLOSED METAL CAN
5. SAWDUST & COMBUSTIBLE WASTE ARE REMOVED DAILY

Table with 3 columns: YES, NO, N/A. 5 rows for checklist items.

NO DANGEROUS SUBSTANCES EXPOSED SUCH AS:

- 1. SHARP OBJECTS
2. SLIPPERY FLOORS, SHOWERS, OR BATHTUBS
3. SCALDING WATER
4. BROKEN GLASS
5. DANGEROUS CHEMICALS

Table with 3 columns: YES, NO, N/A. 5 rows for checklist items.

ELECTRICAL AND HEATING

- 1. ARE ALL ELECTRICAL OUTLETS COVERED PLATES INSTALLED
2. HAVE GROUND FAULT CIRCUITS BEEN TESTED MONTHLY
3. HAS HEATING EQUIPMENT, HOT WATER HEATERS AND GAS APPLIANCES BEEN INSPECTED BY A QUALIFIED SERVICEMAN ANNUALLY? Date: []
4. NO EXPOSED HEATING DEVICES
5. HOT WATER DOES NOT EXCEED 120 DEGREES F.
6. NO EXTENSION CORDS USED AS PERMANENT WIRING

Table with 3 columns: YES, NO, N/A. 6 rows for checklist items.

MACHINERY

- 1. ALL MACHINERY GUARDS ARE INSTALLED AND IN GOOD OPERATING CONDITION
2. IF NECESSARY IS MACHINERY ANCHORED TO THE FLOOR SO IT WON'T SHIFT
3. HANDLES ON HAND TOOLS AND MACHINERY ARE TIGHT AND FREE OF SPLINTERS AND CRACKS
4. ELECTRICAL HAND TOOLS AND MACHINERY ARE GROUNDED UNLESS U.L. APPROVED
5. NO WORN, DETERIORATED OR INADEQUATE INSULATION
6. EACH MACHINE'S ON-OFF SWITCH IS WITHIN REACH OF THE OPERATOR
7. EYE AND EAR PROTECTORS ARE WORN WHEN NECESSARY

Table with 3 columns: YES, NO, N/A. 7 rows for checklist items.

SAFETY EQUIPMENT IS AVAILABLE AND IN GOOD CONDITION IN ALL AREAS

- 1. PROTECTIVE GOWNS
2. DISPOSABLE GLOVES
3. SHOE COVERS
4. C.P.R. MASKS
5. FIRST AID KITS IN BUILDING
6. FLASH LIGHTS (BATTERIES CHECK)
7. BACK SUPPORT BELTS
8. FIRE ALARM/CARBONMONOXIDE/SMOKE DETECTORS CHECKED

Table with 3 columns: YES, NO, N/A. 8 rows for checklist items.

ANNUAL FIRE INSPECTION COMPLETED BY FIRE MARSHAL

Date: []

HAVE BATTERIES BEEN CHANGED ANNUALLY IN ALL BATTERY OPERATED SMOKE DETECTORS?

Table with 3 columns: YES, NO, N/A. 1 row for checklist item.

DATE BATTERIES WERE CHANGED:

Date: []

CORRECTIVE ACTION NEEDED:

Table with 3 columns: YES, NO, N/A. 1 row for checklist item.

SIGNATURE OF PERSON COMPLETING THIS FORM: []

Individual completing this form will type in their name and initial at Admin. Office

**Resource, Support, Development, Inc.
SAFETY CHECKLIST**

TITLE OF PERSON COMPLETING THIS FORM:

Resource, Support, Development, Inc.
SAFETY MEETING

LOCATION:

DATE:

CONDUCTED BY:

ITEMS DISCUSSED:

FOLLOW-UP NEEDED:

EMPLOYEES WHO ATTENDED THE MEETING:

Resource, Support, Development, Inc.
SANITATION, FOOD SERVICE, AND MEDICATION CHECKLIST

LOCATION: _____ ADDRESS: _____ DATE: _____

THE BUILDING PREMISES ARE:

1. FREE OF OFFENSIVE ODORS
2. FREE OF INSECT, RODENTS, AND VERMIN

YES	NO	N/A

SOLID ITEMS ARE:

1. CHANGED IMMEDIATELY
2. STORED IN COVERED CONTAINERS
3. REMOVED FROM PROGRAMMING AREAS DAILY UNLESS CLEANED
4. STORED SEPARATE FROM CLEAN ITEMS

WASTE AND GARBAGE:

1. ARE STORED, TRANSFERRED, AND DISPOSED OF IN A MANNER THAT DOES NOT CREATE A NUISANCE OR PERMIT THE TRANSMISSION OF DISEASE
2. ARE STORED IN NON-COMBUSTIBLE CONTAINERS
3. ARE COLLECTED WEEKLY
4. CONTAINERS ARE CLEANED MONTHLY

FOOD AND STORAGE:

1. DRY OR STAPLE FOOD ITEMS ARE:
 - A. STORED AT LEAST 4" OFF THE FLOOR
 - B. IN A VENTILATED ROOM
 - C. IS NOT SUBJECT TO WASTE WATER BACKFLOW OR CONTAMINATION BY CONDENSATION OR LEAKAGE.
 - D. HEAVY ITEMS CLOSE TO THE FLOOR, MOST USED ITEMS ON MIDDLE SHELVES AND LIGHT ITEMS ON THE TOP SHELVES.
2. PERISHABLE FOODS ARE STORED WITH ADEQUATE REFRIGERATION (BETWEEN 32 & 39 DEGREES F OR 0 & -10 DEGREES C)
3. FOOD SERVED TO AN INDIVIDUAL IS DISCARDED IF NOT CONSUMED

FOOD SERVED BY THE CORPORATION IS SPECIFIED IN ADVANCE IN MENUS THAT ARE:

1. READILY ACCESSIBLE IN FOOD PREPARATION AREAS
2. RETAINED FOR NINETY DAYS
3. PROVIDE A SUFFICIENT AMOUNT AND VARIETY OF FOOD PER DAY, WEEK, MONTH, SEASON
4. EQUAL IN NUTRITIVE VALUE AND NOTED WHEN SUBSTITUTIONS ARE MADE

INDIVIDUALS

1. EAT AT AN-UPRIGHT POSITION OR IN A POSITION THAT IS MEDICALLY INDICATED
2. ARE GIVEN FLUIDS TO PREVENT DEHYDRATION IF NOT ABLE TO OBTAIN FLUIDS ON THEIR OWN

MEDICATIONS

1. ARE STORED IN A LOCKED CONTAINER
2. ARE STORED SEPARATE FROM NON-DRUG ITEMS
3. ARE STORED ACCORDING TO MEDICATION DIRECTIONS
4. TO BE TAKEN EXTERNALLY ARE STORED SEPARATE FROM MEDICATIONS TO BE TAKEN INTERNALLY
5. ARE ADMINISTERED AND RECORDED ONLY BY AUTHORIZED PERSONS
6. THAT ARE DISCONTINUED, OUTDATED, OR THAT HAVE ILLEGIBLE OR MISSING LABELS ARE DISPOSED OF
7. ARE USED ONLY BY THE INDIVIDUAL FOR WHOM THEY WERE PRESCRIBED
8. ARE ABLE TO BE IDENTIFIED UP TO THE POINT OF ADMINISTRATION.
9. ERRORS AND DRUG REACTIONS ARE REPORTED ACCORDING TO WRITTEN POLICY AND DOCUMENTED ON RSD INC'S MEDICATION RESPONSE SHEET
10. ARE NOT ADMINISTERED WITHOUT A WRITTEN OR VERBAL ORDER AUTHENTICATED BY A PHYSICIAN OR A PHYSICIAN'S ASSISTANT

ANNUAL SANITATION INSPECTION COMPLETED BY A MONTANA DEPT. OF HEALTH AND ENVIRONMENTAL SCIENCES: _____ DATE: _____
 CORRECTIVE ACTION NEEDED _____

SIGNATURE OF PERSON COMPLETING THIS FORM: _____

Individual completing this form will type in their name and initial at Admin. Office

TITLE OF PERSON COMPLETING THIS FORM: _____

Resource, Support, Development, Inc.
SAFETY, SANITATION, HEALTH
CORRECTIVE ACTION PLAN

LOCATION OF DEFICIENCY:

Program	Address	City	State

DEFICIENCY DISCOVERED BY:

Individual's Name	Date

DEFICIENCY NOTED (describe in detail):

LOCATION SUPERVISOR'S COMMENTS:

CORRECTIVE ACTION TAKEN:

DATE PUT INTO ACTION:

COPIES OF THIS REPORT SENT TO THE FOLLOWING:

LOCATION SUPERVISOR:

AGENCY ADMINISTRATOR:

SAFETY COMMITTEE CHAIRPERSON:

OTHER:

SIGNATURE OF PERSON COMPLETING THIS REPORT:
Individual completing this form will type in their name and initial at Admin. Office

TITLE OF PERSON COMPLETING THIS REPORT:

VEHICLE CHECKLIST

VEHICLE: _____ LOCATION: _____ DATE: _____

VEHICLE EQUIPMENT IS IN GOOD WORKING ORDER:

1. HEAD LIGHTS HIGH BEAM/LOW BEAM
2. TAIL LIGHTS
3. BACKUP LIGHTS
4. BRAKE LIGHTS
5. SIGNAL LIGHTS FRONT & REAR
6. TIRES (PROPER TIRE PRESSURE INCLUDING SPARE)
7. BRAKES
8. GAUGES
9. HEATER/AIR CONDITIONING
10. OIL LEVEL
11. STEERING
12. DOORS
13. WIPER BLADES
14. DENTS/SCRAPES
15. WHEEL CHAIR LIFT
16. HUB CAPS
17. WINDSHIELD/MIRRORS
18. LICENSE PLATES
19. HAZARD LIGHTS
20. EMERGENCY BRAKES
21. HORN
22. QUARTERLY MAINTENANCE CHECKS ARE COMPLETE

YES	NO	N/A

SAFETY EQUIPMENT IS AVAILABLE AND IN GOOD WORKING CONDITION:

1. SEAT BELTS/WHEEL CHAIR STRAPS
2. FIRE EXTINGUISHER
3. FLASH LIGHT
4. SNAP STICK
5. SPACE BLANKETS (ONE FOR EACH PASSENGER)
6. CANDLES
7. MATCHES
8. SHOVEL
9. SPARE TIRE
10. JACK
11. FIRST AID KIT
12. CAN
13. DISPOSABLE RUBBER GLOVES
14. RESEALABLE BAG FOR BLOOD CONTAMINENTS
15. C.P.R. MASKS
16. HARD CANDY (DIABITIC AND REGULAR)
17. TOILET PAPER
18. CAT LITTER
19. ATTENDS
20. MAGAZINES
21. INSURANCE CARD
22. REGISTRATION
23. EMERGENCY PHONE NUMBERS
24. EMERGENCY PROCEDURE

CORRECTIVE ACTION NEEDED
 DEFICIENCY REPORTED TO: _____ SAFETY REP: _____ AREA MANAGER: _____
 SIGNATURE OF PERSON COMPLETING THIS REPORT: _____

Individual completing this form will type in their name and initial at Admin. Office

TITLE OF PERSON COMPLETING THIS REPORT:

[Redacted area]

Resource, Support, Development, Inc.
VEHICLE MAINTENANCE SCHEDULE AND RECORD LOG
(QUARTERLY)

Listed below are vehicle maintenance check and inspections that should be performed by a qualified service technician every three months:

ADDRESS OF VEHICLE: LICENSE#:
 MAKE OF VEHICLE: YEAR: # MILES:
 SERVICE DATE:

OIL TYPE: OTHER: 5W-30 10W-30 10W-40 5W-40
 NUMBER OF QUARTS ADDED: OIL FILTER TYPE:

CHASSIS LUBE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<hr/>
BRAKE FLUID	Checked <input type="checkbox"/>	Added <input type="checkbox"/>	<hr/>
POWER STEERING FLUID	Checked <input type="checkbox"/>	Added <input type="checkbox"/>	<hr/>
BATTERY	Checked <input type="checkbox"/>	Added <input type="checkbox"/>	<hr/>
WIPER FLUID	Checked <input type="checkbox"/>	Added <input type="checkbox"/>	<hr/>
HYDRAULIC FLUID	Checked <input type="checkbox"/>	Added <input type="checkbox"/>	<hr/>
TIRES	Checked <input type="checkbox"/>	Air Added <input type="checkbox"/>	<hr/>
SHOCKS	Visual Check <input type="checkbox"/>		<hr/>
CV BOOTS	Checked <input type="checkbox"/>		<hr/>
BELTS	Checked <input type="checkbox"/>		<hr/>
LIGHTS	Good <input type="checkbox"/>	Replaced <input type="checkbox"/>	<hr/>
EXHAUST	Checked <input type="checkbox"/>		<hr/>
AIR CLEANER	Good <input type="checkbox"/>	Replaced <input type="checkbox"/>	<hr/>
CRANKCASE BRTHR	Good <input type="checkbox"/>	Replaced <input type="checkbox"/>	<hr/>
PCV VALVE	Checked <input type="checkbox"/>	Replaced <input type="checkbox"/>	<hr/>
TRANSMISSION	Checked <input type="checkbox"/>	Fluid Added <input type="checkbox"/>	<hr/>
TRANSAXLE	Checked <input type="checkbox"/>		<hr/>
TRANSFER CASE	Checked <input type="checkbox"/>		<hr/>
DIFFERENTIAL	Front Checked <input type="checkbox"/>	Fluid Added <input type="checkbox"/>	<hr/>
	Rear Checked <input type="checkbox"/>	Fluid Added <input type="checkbox"/>	<hr/>
RADIATOR	Checked <input type="checkbox"/>	Added <input type="checkbox"/>	<hr/>
		Antifreeze Added <input type="checkbox"/>	<hr/>
WIPERS	Good <input type="checkbox"/>	Replaced <input type="checkbox"/>	<hr/>

COMMENTS:

Resource, Support, Development Inc.
VEHICLE MAINTENANCE SCHEDULE AND RECORD LOG
(ANNUAL)

Listed below are vehicle maintenance checks and inspections that should be performed by a qualified service technician at least once a year:

ADDRESS OF VEHICLE	<input style="width: 100%;" type="text"/>	LICENSE #:	<input style="width: 100%;" type="text"/>
MAKE OF VEHICLE	<input style="width: 100%;" type="text"/>	YEAR	<input style="width: 100%;" type="text"/>
SERVICE DATE	<input style="width: 100%;" type="text"/>	# MILES	<input style="width: 100%;" type="text"/>
TIRES ROTATED			
	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
TUNE - UP			
SPARK PLUGS	CHECKED <input type="checkbox"/>	CHANGED <input type="checkbox"/>	
POINTS	CHECKED <input type="checkbox"/>	CHANGED <input type="checkbox"/>	
TIMING	CHECKED <input type="checkbox"/>	ADJUSTED <input type="checkbox"/>	
INSPECT DISC BRAKE SYSTEM	CHECKED <input type="checkbox"/>	LUBRICATED <input type="checkbox"/>	
INSPECT DRUM BRAKE SYSTEM HOSE, LINES	CHECKED <input type="checkbox"/>	REPLACED <input type="checkbox"/>	
INSPECT DRIVESHAFT U-JOINT IF EQUIPPED WITH GREASE FITTING	CHECKED <input type="checkbox"/>	LUBRICATED <input type="checkbox"/>	
INSPECT FRONT WHEEL BEARINGS	CHECKED <input type="checkbox"/>	LUBRICATED <input type="checkbox"/>	