NEW YORK STATE DEPARTMENT OF HEALTH
NURSING HOME AND ICF SURVEILLANCE
Adult Day Health Care Program (ADHCP)

ADHCP SURVEY REPORT

The following survey is required to document compliance with certification requirements of Article 28 Adult Day Health Care Programs.

Programs are to submit this ADHCP Survey Report to **ADHCP.HCBS@health.ny.gov**

Sponsoring Facility Name _____PFI_____

ADHCP Name _____

_____
Number and Street City Zip Code

CERTIFICATION STATEMENT

The electronic signatures below attest that the following survey is complete with information that is true to the best of our knowledge.

_____ / / ____
Name of Nursing Home Administrator Electronic Signature Date

_____ __/___/__
Name of ADHCP Director Electronic Signature Date

Has your ADHCP reopened? If Yes, date reopened: _____

If No, when do you plan to reopen? _____

If ADHCP is permanently closed, was a closure plan submitted to DOH? Yes___ No___

If program has reopened, continue completing this survey.

If program is not reopened, do not proceed with survey, and submit pages 1 and 2 now.

Definitions 425.1 (d), (f)

1.) (a) What is your Program's approved registrant capacity for a session? _____

(b) Identify the days and operating hours of each approved session (e.g., Mon.-Sat., 9-3)?

Session 1 (Days) _____ (Hours) _____
Session 2 (Days) _____ (Hours) _____
Session 3 (Days) _____ (Hours) _____

Changes in Existing Program 425.3 (a)-(d)

2.) Have changes been made to the program since reopening as described in the regulations. Yes____No____ If yes, describe. _____

_____

_____

General Requirements for Operation 425.4 (a) (3)

3.) (a) Please paste an electronic copy of the Registrant's Bill of Rights provided to each Registrant here.

(b) Do you have policy and procedures to protect registrants from physical and psychological abuse? Yes ____ No _____

(c) Have all staff been trained in these policy and procedures? Yes ____No____

Adult Day Health Care Services 425.5 (a)(9)

4.) Identify arrangements made for provision of dental services for program registrants.

Directly provide ____, refer ____, both_____

General Record 425.19 (c)

5.) (a) Since reopening, have you been inspected by any governmental agency regarding fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, water supply or other relevant health and safety requirements? Yes ____ No____

b) If so, were you officially notified that you were in violation of any laws or regulations regarding such inspection? Yes ____ No____

If yes, **paste an electronic copy** of the governmental agency report and describe any actions taken to address any violation.

_____
_____
_____

General Requirements for Operation 425.4 (b); (c)(7)

6.) (a) Has your program ensured that employees and other persons providing registrant services in your facility are licensed, registered or certified in accordance with applicable laws and regulations? Yes ____No ____

(b) Provide the name and title responsible for:

Day-to-day direction, management, and administration:

_____ _____

Coordination of services

_____ _____

(c) List the names of the Article 28 and Article 36 entities with which your program has transfer or affiliation agreements.

_____

_____

_____

_____

_____

Registrant Care Plan 425.7 (b)(1)

7. Provide the name and title of a professional person responsible for coordinating registrant's plan of care:

_____

Name Title

Admission, Continued Stay and Registrant Assessment 425.6 (a)(2)(i) ;(d)

8.) (a) Have you, since reopening, admitted registrants for a period less than 30 days?
Yes ____No ____

(b) What is the average daily census, by session?

Session 1 _____ Session 2 _____ Session 3 _____

(c) How many days where you open to receive registrants?

Session 1 _____ Session 2 _____ Session 3 _____

(d) For each session since reopening, provide the dates and registrant census of the days in which the approved capacity was exceeded. (Please refer to question 1(b) **and paste an electronic copy of the report here.**

Medical Services 425.9 (a)

9.) Provide the name of the medical board/medical advisory committee/medical director or consulting physician that is responsible for overseeing medical services. If a board or committee, please list members:

_____ _____

_____ _____

_____ _____

_____ _____

Nursing Services 425.10 (b), (d)

10.). (a) Does the program have a registered nurse on site during all hours of the program operation on the weekdays? Yes ____No____

(b) If the program provides only LPN services on the weekend, how is a registered nurse available to provide immediate direction or consultation?

_____

_____

Food and Nutrition Services 425.11 (d)

11.) Provide the name and title of the qualified Dietitian who directs the program nutrition services.

Name: _____ Title: _____

Social Service 425.12 (a)

12.) (a) Provide the name and title of the qualified social worker for the nursing home. (See 415.5(g)(2))

Name: _____ Title: _____

(b) Provide the name of the person employed to direct the social services of the ADHCP?

Name: _____ Title: _____

Rehabilitation Therapy Services 425.13 (b)

13.) Do you provide:

Physical therapy Yes ___ No____Onsite _____ Offsite _____

Occupational therapy Yes ___ No ___ Onsite _____ Offsite _____

Speech language pathology Yes ____No ___ Onsite _____ Offsite _____

Activities 425.14 (a), (c), (e)

14.) (a) Attach an **electronic copy** of the activity calendar since reopening.

(b) Does your program include the use of volunteers? Yes ____No____

(c) Does your program provide activities offsite in the community? Yes ___No ___

(d) If yes to (c) above, does your program provide transportation to those offsite activities? Yes ___ No___

General Records 425.19 (a) (1) – (3)

15.) (a) Does the program maintain a chronological admission register? Yes ___ No____

(b) Does the program maintain a chronological discharge register? Yes____ No ___

(c) Does the program maintain a daily census record? Yes ____No____

Clinical Records 425.20 (f)

16.) Are clinical records stored and maintained in accordance with regulations? Yes ____No___

Program Evaluations 425.22

17.) Provide the name and title of a person who can authoritatively discuss your quality improvement program:

Name _____Title_____

General Requirements for Operation 425.4 (a)(1)

18.) Medical waste removal contractor name, contact person and phone number:

Contractor Name_____

Contact Person_____ Phone _____

Emergency Power 10NYCRR 415.29

If the program is in a part of a nursing home patient care building:

19). (a) Is the emergency generator connected as required? Yes ____No ____

(b) Is the emergency generator exercised under load for a least 30 minutes at intervals since reopening? Yes ____ No____

2000 Edition of NFPA 101, [*Life Safety Code]* Chapter 17 -Day Care Occupancy

20.) (a) Are required automatic sprinkler systems, fire detection and alarm systems, smoke control systems, exit lighting and any other item required for fire protection, monitored routinely to assure proper operating conditions? Yes ___No___

(b) Is any fire protection equipment requiring test or periodic operation to assure its maintenance tested or operated as specified? Yes ___No ____

(c) Date of last inspection by contractors of:

Month/ Date/ Year

automatic sprinkler systems _____

fire detection and alarm systems _____

smoke control systems _____

Staff Training and Drills, 425.4 (a)(1) 10 NYCRR 415.29

21.) Record the date and session time of all fire drills held in your program since reopening [2000 LSC 16.7.2 & 17.7.2]. Note - Programs located in the inpatient nursing home space (those programs that are not separated from the nursing home by a two-hour fire wall) are only required to do 4 fire drills per year [2000 LSC 18.7.1 & 19.7.1].

SESSION	DATE	TIME
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Disaster Preparedness 425.4(a)(1) and 10 NYCRR 415.26(f)

22.) Record the dates and types of disaster response (other than fire) rehearsed in your facility since reopening.

Type of Disaster	Date
_____	_____
_____	_____
_____	_____

Please attest whether the following HCBS Requirements are true for this ADHC program:

Registrants of the program are integrated into the broader community to the same degree of access as individuals not receiving Medicaid HCBS – such as able to control personal resources, seek employment / work in and receive services in the community, and engage in community life.

Yes_____ No _____If no explain _____

Registrants can select options based on their needs, and preferences and these are documented in the registrants' person-centered service plan.

Yes_____ No _____If no explain _____

Registrants' rights of privacy, dignity, respect, freedom from coercion, and restraint are ensured.

Yes_____ No _____If no explain _____

Registrants are given independence in making life choice such as daily activities, physical environment, and with whom to interact.

Yes_____ No _____If no explain _____

Residents have choice regarding services and who provides them; freedom to control their own schedules, and activities; have access to food at any time; and to have visitors of their choosing.

Yes_____ No _____If no explain _____

The setting is physically accessible to all registrants.

Yes_____ No _____If no explain _____