

**NEW YORK STATE DEPARTMENT OF HEALTH  
DIVISION OF QUALITY SURVEILLANCE**

**Adult Day Health Care Program (ADHCP)**

General Instructions

All Programs are requested to submit the attached ADHCP Survey Report to the New York State Department of Health.

This form will be used as a data source document for certification of compliance with Article 28 of the Public Health Law. The report should cover the current status of your Program, the following specific instructions are to be followed:

Complete the sponsoring facility name and permanent facility identifier (PFI) on page 2 and the Program name on each subsequent page. The form should be completed and returned to:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE \_\_\_\_\_

**ADHCP SURVEY REPORT**

**CERTIFICATION STATEMENT**

THE FOLLOWING STATEMENT MUST BE READ AND A CERTIFICATION OF SUCH BE SIGNED BY THE FACILITY ADMINISTRATOR AND THE ADULT DAY CARE PROGRAM DIRECTOR. PLEASE MAKE SURE THIS IS ACCURATE AND COMPLETE.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT THE INFORMATION FURNISHED IN THIS DOCUMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF NURSING HOME ADMINISTRATOR

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PROGRAM DIRECTOR

NEW YORK STATE DEPARTMENT OF HEALTH  
DIVISION OF QUALITY SURVEILLANCE

**Article 28 Survey**  
**ADHCP Survey Report**

PFI: \_\_\_\_\_ Sponsoring Facility: \_\_\_\_\_

ADHCP Name: \_\_\_\_\_

ADHCP Address: \_\_\_\_\_

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

Definitions 425.1 (d)(1)

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

(b) What are the days and the operating hours of each approved session ( eg. 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 you made any changes to your existing program in the last 12 months as described in the regulation?

Y/N Describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

General Requirements for Operation  
425.4 (a)(3)(i-v)

3.) (a) Please provide a copy of the Registrant's Bill of Rights provided to each registrant.

(b) Do you have policy and procedures to protect registrants from physical and psychological abuse? Y/N

(c) Have all staff been trained in these policy and procedures? Y/N

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

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

- 4.) What arrangements are made for provision of dental services for program registrants? (e.g., directly provide or refer)

\_\_\_\_\_  
\_\_\_\_\_

General Record 425.19 (c)

- 5.) (a) In the last year, have you been inspected by any governmental agency in regard to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, water supply or other relevant health and safety requirements? Y/N
- b) If so, were you officially notified that you were in violation of any laws or regulations in regard to such inspection? Y/N  
If yes, attach governmental agency report and describe any action's taken to address any violation.

General Requirements for Operation  
425.4 (b)(2)(i-v); (b)(1); (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? Y/N

- (b) Provide the name and title responsible for:

Day-to-day direction, management, and administration \_\_\_\_\_  
\_\_\_\_\_

Coordination of services \_\_\_\_\_

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

- (c) Name 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 who is responsible for coordinating registrant's plan of care: \_\_\_\_\_

Admission, Continued Stay and Registrant Assessment  
425.6 (a)(2)(i) ; (4)(d)

- 8.) (a) Have you, in the last 12 months, admitted registrants for a period less than 30 days? Y/N
- (b) What was the average daily census, by session, for the past 12 full months?  
Session 1 \_\_\_\_\_ Session 2 \_\_\_\_\_ Session 3 \_\_\_\_\_
- (c) How many days were you open to receive registrants in the past 12 full months?  
Session 1 \_\_\_\_\_ Session 2 \_\_\_\_\_ Session 3 \_\_\_\_\_
- (d) For each session in the past 12 full months, provide dates and registrant census for the days in which the approved capacity was exceeded. (Please refer to question 1(b) and attach report).

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

Medical Services  
425.9 (a)(1-5)

- 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? Y / N

- (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 nutrition services of the program.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

Social Services  
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) Who is employed to direct the social services of the ADHCP?

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Rehabilitation Therapy Services  
425.13 (b)

- 13.) Do you provide:

Physical therapy Y/N Onsite \_\_\_\_\_ Offsite \_\_\_\_\_

Occupational therapy Y/N Onsite \_\_\_\_\_ Offsite \_\_\_\_\_

Speech language pathology Y/N Onsite \_\_\_\_\_ Offsite \_\_\_\_\_

Activities  
425.14 (a)(c)(e)

- 14.) (a) Attach the activity calendar for March, June, September and December.

(b) Does your program include the use of volunteers? Y/N

(c) Does your program provide activities offsite in the community? Y/N

(d) If yes to ( c ) above, does your program provide transportation to those offsite activities? Y/N

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

General Records  
425.19 (a)(1-3)

- 15.) (a) Does the program maintain a chronological admission register in accordance with 425.19 (a)(1)? Y/N
- (b) Does the program maintain a chronological discharge register in accordance with 425.19 (a)(2)? Y/N
- (c) Does the program maintain a daily census record in accordance with 425.19 (a)(3)? Y/N

Clinical Records  
425.20 (e)

- 16.) Are clinical records stored and maintained in accordance with 425.20 (f)? Y/N

Program Evaluations  
425.22

- 17.) Provide the names 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:

\_\_\_\_\_



Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

Emergency Power  
10NYCRR 415.29

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

- 19.) (a) Is the emergency generator connected as required? Y/N
- (b) Is the emergency generator exercised under load for a least 30 minutes at intervals of not over 30 days? Y/N

1997 Edition of NFPA 101 [Life Safety Code] Chapter 31-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? Y/N
- (b) Is any fire protection equipment requiring test or periodic operation to assure its maintenance tested or operated as specified? Y/N

(c) Date of last inspection by contractors of:

	Month/ Date/ Year
automatic sprinkler systems	_____
fire detection and alarm systems	_____
smoke control systems	_____

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

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

21.) Record the date and session time of all fire drills held in your program within the past 12 months [97 LSC 30-7.1& 31-7.1]. 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 [97LSC 12-7.1.2 & 13-7.1.2].

	SESSION	DATE	TIME
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

Program Name: \_\_\_\_\_

Reporting Period: \_\_\_\_\_

Disaster Preparedness 425.4(a)(1) and 10NYCRR 415.26(f)
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22.) Record the dates and types of disaster response (other than fire) rehearsed in your facility within the last 12 months.

Type of Disaster	Date
_____	_____
_____	_____
_____	_____