NEW YORK STATE OF OPPORTUNITY. Department of Health

ADHCP REGISTRANT REVIEW

Provider Name: _____ **PFI:** _____

Onsite Review Date _____

Number Registrants expected by ADHCP upon surveyor entrance: _____

***Actual number of Registrants attending ADHCP upon surveyor entrance:** _____
***up to 10% over the approved capacity on any given day; however, the average annual capacity may not exceed the approved capacity of the operator's program**

Request copy of roster of attendees and roster of services provided for the day of survey.

Registrant Sample Number: _____

Registrant Name: _____ **Gender:** _____ **MALE** _____ **FEMALE**

DOB: _____ **Date Entered Program** _____

425.6(a) (1) - #Days per Week Registered (at a minimum at least 1 day per week): _____

Type of Transportation: _____

Evidence of:	**Yes**	**No**	**Evidence of:**	**Yes**	**No**
Emergency Contact **[425.19(3)]**			Influenza Vaccination		
Advance Directive (CPR/DNR)			Pneumococcal vaccine		
HCP			PPD		

425.6 - INITIAL PRACTITIONER (PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT) RECOMMENDATION (prior to admit):

Done: Yes No Date: _____

Signed: Yes No Date: _____

By whom (include type of license): _____

If complete, is this timely: Yes No

425.6 - INITIAL ASSESSMENT BY THE OPERATOR OR THE MANAGED LONG TERM CARE PLAN (MLTC) (prior to admit):

Assessment instrument used: _____

Done: Yes No Date: _____

Signed: Yes No Date: _____

ADHCP REGISTRANT REVIEW

By whom (include type of license): _____

Circle one: ADHC MLTC

If complete, is this timely: Yes No

425.9(c) - INITIAL MEDICAL HISTORY AND PHYSICAL EXAM (6 weeks before or 7 days after admission) including diagnostic laboratory and x-rays services, as medically indicated:

Done: Yes No Date: _____

Signed: Yes No Date: _____

By whom (include type of license): _____

If complete, is this timely: Yes No

425.10(d) - REGISTERED NURSE ON-SITE ALL HOURS OF PROGRAM OPERATION:

On-site: Yes No

If No, please describe the issue: _____

425.10(b) - INITIAL NURSING EVALUATION by ADHC (on-site) or by MLTC PLAN (prior to admit):

Done: Yes No Date: _____

Signed: Yes No Date: _____

By whom (include type of license): _____

Circle one: ADHC MLTC

If complete, is this timely: Yes No

425.10(a) - QUARTERLY NURSING EVALUATION by ADHC or by MLTC PLAN:

Done: Yes No Most Recent Date: _____ Previous Date: _____

Signed: Yes No Most Recent Date: _____ Previous Date: _____

By whom (include type of license): Most Recent: _____ Previous: _____

Circle one: ADHC MLTC Circle one: ADHC MLTC

If complete, is this timely? Yes No

NEW YORK STATE OF OPPORTUNITY. Department of Health

ADHCP REGISTRANT REVIEW

CURRENT REASON FOR ATTENDING ADHC:

Socialization		Restorative Rehab	
Health Care Monitoring/Nursing Management		Maintenance Rehab	
Maintain Wellness/Delay Deterioration		Informal Support Supplement	
Respite for Informal Services		Personal Care Services	
Care Coordination of Services		Congregate Setting	
Reduced Cognitive Functioning		Reduced Psychological Functioning	

DIAGNOSES RELATED TO CURRENT USE OF SERVICE:

Primary: _____

Secondary: _____

Other Diagnoses: _____

425.17 - PHARMACY REVIEW (every 6 months):

Done: Yes No Most Recent Date: _____ Previous Date: _____

Signed: Yes No Most Recent Date: _____ Previous Date: _____

By whom (include type of license): Most Recent: _____ Previous: _____

If complete, is this timely? Yes No

425.11 (subpart 415.14) - FOOD and NUTRITION SERVICES (must employ a qualified dietitian):

Done: Yes No Most Recent Date: _____ Previous Date: _____

Signed: Yes No Most Recent Date: _____ Previous Date: _____

By whom (include type of license): Most Recent: _____ Previous: _____

If complete, is this timely? Yes No

Any special diet/recommendations: _____

425.6(a) (3) - PRACTITIONER CERTIFICATION OF NEED FOR CONTINUED SERVICES (Every 6 months):

Done: Yes No Most Recent Date: _____ Previous Date: _____

Signed: Yes No Most Recent Date: _____ Previous Date: _____

ADHCP REGISTRANT REVIEW

By whom (include type of license): Most Recent: _____ Previous: _____

If complete, is this timely? Yes No

425.7 - CARE PLAN: INITIAL FOCUS AND GOALS (within 5 visits or within 30 days of registration; whichever is sooner):

Done: Yes No Date: _____

Signed: Yes No Date: _____

By whom (include type of license): _____

If complete, is this timely: Yes No

425.7(d) (3) - CARE PLAN UPDATED (every 6 months or when condition warrants):

Done: Yes No Most Recent Date: _____ Previous Date: _____

Signed: Yes No Most Recent Date: _____ Previous Date: _____

By whom (include type of license): Most Recent: _____ Previous: _____

If complete, is this timely? Yes No

Does the care plan adequately meet the needs of the registrant? Yes No
If no, please describe the issue:

_____

_____

_____

_____

_____

_____

_____

424.4(b) (1) - CASE MANAGEMENT Needs of registrant are coordinated with the services provided by the ADHCP and other community providers and agencies:

Done: Yes No

ADHCP REGISTRANT REVIEW

If No, describe the issue:

_____

_____

_____

_____

_____

_____

Other agencies involved:

_____

_____

_____

_____

_____

_____

_____

Review medical record to verify services documented for that registrant on day of survey. Please check off what services are in the care plan, what the registrant is receiving, and by whom. Add additional information as needed:

Service	In IPOC	Received Care	By Whom	Evidence: MR, Observation, Interview
Nursing care				
Therapy (PT, OT, SLP)				
Med Admin during program				
ADL's during program				
Independent ADL's				
Oxygen				
Suctioning				
Skin Integrity: Surgical				
Skin Integrity: Pressure				
Skin Integrity: Injury				
Catheter				
Ostomy Care				
Health Education				
Diabetes Management				

ADHCP REGISTRANT REVIEW

Bowel/Bladder Rehab: Toileted				
Bowel/Bladder Rehab: Check and Change				
Nursing Rehab				
Transfer/Discharge Plan (if applic.) [425.7(a)]				

Other, describe (parenteral fluids and meds, respiratory therapy, tube/NG feedings, etc.):

_____

_____

_____

_____

_____

Record the number of days per week of therapy received during the past week (date): _____

Therapy	Maintenance	Restorative	Days per week
Physical Therapy			
Occupational Therapy			
Speech Language Pathology			

Briefly describe observations and care concerns (i.e.…POC followed for therapy and given as ordered, treatment and adjusted to meet the current needs of the registrant, how was the time spent in the session observe):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADHCP REGISTRANT REVIEW