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.

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) _____________

2.) Have changes been made to the program since reopening as described in the regulations. Yes___ No___ If yes, describe. ______________________________________________________
________________________________________________________________________
________________________________________________________________________
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____

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

   Directly provide ____, refer ____ , both ______

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.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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
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.)

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:

    ___________________________  ___________________________
    ___________________________  ___________________________
    ___________________________  ___________________________
    ___________________________  ___________________________
    ___________________________  ___________________________
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: _____________________________
13.) Do you provide:

Physical therapy  Yes ___  No____ Onsite _____ Offsite ______
Occupational therapy  Yes ___  No ___ Onsite _____ Offsite ______
Speech language pathology Yes ____No ___ Onsite _____ Offsite ______

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____

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____

16.) Are clinical records stored and maintained in accordance with regulations?  Yes ____No____
17.) Provide the name and title of a person who can authoritatively discuss your quality improvement program:

Name ___________________________________ Title ________________________________

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

   Contractor Name__________________________________________________________

   Contact Person____________________ Phone ______________________

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 ____
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:

- automatic sprinkler systems
- fire detection and alarm systems
- smoke control systems

Month/ Date/ Year

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].

<table>
<thead>
<tr>
<th>SESSION</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Type of Disaster</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ______________________________________________