January 22, 2020

Re: DAL NH 19-18
Adult Day Health Care Program Survey Report

Dear Nursing Home Administrator:

This letter is to notify you of the attached Adult Day Health Care Program Survey Report (PSR) questionnaire which must be completed for each Adult Day Health Care Program that your facility operates. The questionnaire is based on New York State Title 10 NYCRR Part 425 and is used by the Department of Health as a resource document to determine regulatory compliance for your Adult Day Health Care Program.

The PSR is to be completed by the Adult Day Health Care Program for the period from October 1, 2018 through September 30, 2019. The completed PSR questionnaire must be mailed to the NYSDOH Regional Office in which the program is located by February 28, 2020.

Nursing home administrators are required to certify the accuracy of the report. Thereafter, at the time of an onsite visit, the program will be given an opportunity to update the questionnaire. If you have any questions, please contact the appropriate Regional Office Program Director.

Thank you for your cooperation in submitting the completed PSR questionnaire on time, and your continued efforts to provide quality care and services to ADHCP registrants.

Sincerely,

Sheila McGarvey
Director
Division of Nursing Homes and ICF/IID Surveillance
Center for Health Care Quality and Surveillance

Attachment
NEW YORK STATE DEPARTMENT OF HEALTH
NURSING HOME AND ICF 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
NURSING HOME AND ICF SURVEILLANCE

Article 28 Survey
ADHCP Survey Report

PFI: __________ Sponsoring Facility: ________________________________

ADHCP Name: ____________________________________________________________

ADHCP Address: __________________________________________________________
Program Name: ____________________________________________________

Reporting Period: __________________________________________________

Definitions 425.1 (d),(f)

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 (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 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)

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
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); (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.

__________________________
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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);(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)

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: _______________________________
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 (f)

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)
Program Name: ____________________________________________________

Reporting Period: ___________________________________________________

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

**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 at least 30 minutes at intervals of not over 30 days?  Y / N


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:

- automatic sprinkler systems
  - Month/ Date/ Year
- fire detection and alarm systems
  - Month/ Date/ Year
- smoke control systems
  - Month/ Date/ Year
21.) Record the date and session time of all fire drills held in your program within the past 12 months [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].

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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.

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