Adult Day Health Care Council

TO: ADHCC Members
FROM: Anne Hill, Executive Director
DATE: January 2, 2019
SUBJECT: **2018 Program Survey Report for ADHC Providers**

This morning, the Department of Health (DOH) posted the *Dear Administrator Letter* and 2018 Program Survey Report (PSR). The DAL is from Ms. Shelly Glock, director, Division of Nursing Home and ICF/IID Surveillance.

In the DAL, DOH requests completion and return of the PSR by Jan. 31, 2019. Please note, that even if you updated your PSR recently for DOH surveyors, you still must complete a new 2018 PSR by Jan. 31st.

Members are advised that they should complete the **PSR for the period Oct. 1, 2017 through Sept. 30, 2018.** The PSR must **be returned to the DOH regional office where the ADHC program is located,** and the name and address of the regional office should be entered in the PSR on pg. 1 in the section marked "General Instructions." The addresses of the DOH regional offices are listed below.

Please note that you should update your 2018 PSR as changes occur over the course of 2019. This is similar to the practice in the nursing home. DOH survey staff will give you an opportunity to update the PSR during survey.

The remainder of the form remains unchanged, and while it is self-explanatory, there have been some questions in the past regarding the PSR. Listed below are responses to frequently-raised issues.

- ✓ With respect to question 6 (c) of the PSR on pg. 5, please be advised that Article 28 entities are hospitals and nursing homes and that Article 36 entities are certified home health agencies (CHHAs), licensed home care agencies, long term home health care programs and AIDS home care programs. Also, please note that if a program has transfer or affiliation agreements separate from the sponsoring facility's agreements, as may often happen with off-site programs, the program should list these separate agreements. If, however, the ADHC program is included as a party to the sponsoring facility's transfer or affiliation agreements, you may list the entities with which the sponsoring facility has transfer or affiliation agreements in this section. Be aware, however, that the sponsoring facility's transfer/affiliation agreement, if so used, should somehow identify/incorporate the ADHC program as part of the agreement. Transfer and affiliation agreements should be in writing. With respect to transfers, you do not have to list every entity to which you have ever transferred a registrant, but you should list the entities to which you transfer on a regular basis.

- ✓ **Question 8 (a) on pg. 5 asks "Have you in the last 12 months, admitted registrants for a period of less than 30 days? Y/N"** Programs should answer "Yes" for any and all registrants that were enrolled for less than 30 days. You should answer, "Yes" even if your intention at the time of admission was that a registrant would be enrolled for more

than 30 days. There should be documentation in the record indicating why the registrant was enrolled for less than 30 days.

- ✓ **Question 8 (d) on pg. 5 "For each session in the past 12 full months, provide dates and registrant census for the dates in which the approved capacity was exceeded."** The approved capacity is the number of registrants a program may serve at any one time. This number is assigned by the Department of Health. The DOH is aware that under Section 425.6 (4) (d) "the operator, may admit on any given day, up to 10% over the approved capacity for the program," and the Department will expect to see all the days when the program exceeded its capacity listed in response to this question. Members should report all of the days in the 12 month-period that the program exceeded its capacity, regardless of whether or not the registrant(s) that put the program over its capacity on a given day was a Medicaid recipient or whether or not the program billed for the visit(s) of the individual who exceeded the program's capacity.

Capital District Regional Office Ms. Kimberly Valente Program Director NYS Department of Health 875 Central Ave Albany, NY 12206 Phone: 518-408-5372	Central New York Regional Office Ms. Cindy Pullano Program Director NYS Department of Health 217 South Salina Street Syracuse, NY 13202 Phone: 315-477-8525
Western Regional Office-Buffalo Ms. Gloria Duffey Acting Program Director NYS Department of Health 584 Delaware Avenue Buffalo, NY 14202 Phone: 716-847-4320	Western Regional Office-Rochester Ms. Gale Ajavon Interim Program Manager NYS Department of Health 335 East Main Street Rochester, NY 14604 Phone: 585-423-8020
Five boroughs of New York City Ms. Leah Ryer Program Director Metropolitan Area Regional Office NYS Department of Health 90 Church Street 15th FL New York, NY 10007 Phone: 212-417-4999	For Dutchess, Putnam, Westchester, Orange, Ulster, Sullivan or Rockland counties Ms. Leah Ryer LTC Program Director Metropolitan Area Regional Office NYS Department of Health 145 Huguenot Street, 6th Floor New Rochelle, NY 10801 Phone: 914-654-7058
For Nassau or Suffolk counties Ms. Leah Ryer LTC Program Director Metropolitan Area Regional Office NYS Department of Health Court House Corporate Center 320 Carlton Ave., Suite 5000 Central Islip, NY 11722 Phone: 631-851-3611	

Should you have any questions about the PSR, please contact ahill@leadingage.org 518-867-8383 ext.141

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 28, 2018

Re: DAL NH 18-10 Adult Day Health Care Program Survey Report Letter with Questionnaire

Dear Nursing Home Administrator:

The purpose of this letter is to distribute the Program Survey Report (PSR) questionnaire for the Adult Day Health Care Program.

The attached PSR questionnaire 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, 2017 through September 30, 2018. The completed PSR questionnaire must be mailed to the NYSDOH Regional Office in **which the program is located by January 31, 2019**.

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,

Shelly Glock, Director
Division of Nursing Homes & ICF/IID Surveillance
Center for Health Care Providers Services and Oversight

Attachment

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF QUALITY SURVEILLANCE

Adult Day Health Care Program (ADHCP)

General Instructions

All Programs shall 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 (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)(i-vi)

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)(10)

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

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? 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 [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.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

Program Name: _____

Reporting Period: _____

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

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
_____	_____
_____	_____
_____	_____