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

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) questionniare 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 (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)

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); (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);(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: _____

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 (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 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) 10 NYCRR 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 10 NYCRR
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
_____	_____
_____	_____
_____	_____