SERVICE SPECIFIC ON-SITE REVIEW

Adult Day Health
Revised 05/04/2017

A. List the date of the License issued by the Department of Public Health (attach copy of License).

B. List the maximum number of participants who may be in the care of your Program at any one time (Licensed Program Capacity).

C. What is the average time between ASAP referral and start of service?

D. Describe your procedure for action in case of the following emergencies:
   1. Fire

   2. Loss of power (lights and/or heat)

   3. Hurricanes and snowstorms

   4. Elopement

   5. Medical emergencies, including criteria for calling emergency telephone access number 911, emergency transport. Attach written policy.

E. Describe your Enrollment policy, including restrictions. Describe how the policy ensures that your Program provides care and services appropriate to participants with cognitive needs.

F. Describe your Discharge policy, including conditions when discharge is initiated by the Program.

G. Describe your policy to ensure that all Program personnel in direct contact with participants are trained in emergency procedures and that licensed nurses and program aides are certified in cardiopulmonary resuscitation (CPR) and basic first aid by an approved instructor.

H. Describe how your Program meets the requirement to provide the following services:
   1) Nursing Care;

2) Service coordination;

3) Therapeutic activities, including providing a separate space for persons with advanced Dementia;

4) Dietary services, including the responsibility of your Program's Registered Dietician; and,

5) Medication management services, including the supervisory responsibility of your Program's Registered Nurse

I. Describe how your Program ensures that the licensed Nursing staffing ratio requirement is met based on licensed program capacity.

Describe how your Program ensures that the Program Aide and Direct Care Staff ratio requirement is met based on the number of participants attending the Program.

J. Are meals prepared on site?

K. List the special diets that your site can accommodate.

L. List the AM & PM snacks served during the average week.

Alzheimer's Day Program Providers (separate Attachment A) Alzheimer's Day Programs provide specialized services to address the needs of people with Alzheimer's disease and related disorders (ADRD) and other dementias.

A. List your requirements for admission.

B. Describe how activities are designed to meet the needs of high and low functioning groups.

C. Describe how you ensure that your Program maintains a staff to participant ratio of at least 1:4 on site. Also, describe how you ensure the presence of at least 2 staff members at all times.

Provider employee who completed this form

Name: _____   Date: _____

Adult Day Health

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

EMPLOYEE Record Review					
Provider Date Monitor					
Start Date & Termination Date, if applicable					
Number of reference checks					
CORI Check					
Orientation Date					
Job Description					
License(s)/ Certificate(s) Current/expired?					
Physical: Most recent Date (Requirement) Pre-employment Physical completed within 12 months of employment And Physical completed every two years					
TB: Most recent Date (Requirement) Pre-employment TB History and Risk Assessment with additional screening as indicated within 3 months prior to employment					

(Department Bureau of Infectious Disease Guidelines) And Annual TB Risk Assessment/Symptom Review in accordance with Bureau.				
Emergency Procedures Training: Most recent Date (all Program personnel) And CPR/Basic First Aid: Most recent Date (Licensed Nurses/Program Aides)				
Ongoing training: Dates (Requirement) 12 hours/year relevant in-service for employees who interact with participants				
OIG monthly checks				
Annual Performance Evaluation: Most recent Date				
Comments				

Adult Day Health

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CONSUMER Record Review					
Provider Date Monitor					
ASAP Authorization					
Name; address; phone; DOB, SAMS ID					
Emergency contact(s) name and phone					
Physician(s) name and phone					
Preferred hospital name and phone					
Medical/social diagnosis					
Current CM/RN and phone					
Service start date & Termination Date, if applicable					
Service plan					
Care Plan: Signed and dated					
Consumer Enrollment: Agreement And Discharge Plan					
Comments					
NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate "on screen".					
Name and Position of Provider Direct Demonstrator					