

ITEMS HIGHLIGHTED IN GREEN INDICATE THE CHANGES MADE TO THIS FORM.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
ADULT DAY CARE SERVICES
PROGRAM CERTIFICATION REPORT
FACE SHEET

- Certification
- Recertification**
- Denial or Revocation
- Change in Program Director/Operator

- ACTION REQUESTED
- Change of Capacity
- Change of Program Location
- Provisional

<input type="checkbox"/> Public <input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit Type of Program: <input type="checkbox"/> Adult Day Care Home <input type="checkbox"/> Adult Day Care Center	Date of Report: _____
Program Offers Specialized Care for <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> OTHER _____ <input type="checkbox"/> NONE	Certification Period: FROM: TO:
Name of Program:	Capacity:
Address (Street, City, Zip Code):	County:
Mailing Address (if Different from Above):	Program Telephone (Area Code and No.):
Name of Director/Operator:	

NOTE: Please check the appropriate blocks to indicate which materials are attached. Initial certification requires everything on this list. **Recertification requires those items in bold and the other items only if changed since the program's last recertification.**

- Program Policy Statement
- Organizational Diagram for Centers
- Job Descriptions
- Personnel Policies
- 732-a-ADS or Equivalent Annual Budget**
- Floor Plan (change of address, change of capacity, or when structural building modifications have been made)
- Fire Inspection Report, DOA-1498 or the equivalent**
- Building Inspection Report, DOA-1499 or the equivalent (change of address or when structural building modifications have been made)
- Sanitation Evaluation Report, DENR-4054 or the equivalent**
- Articles of Incorporation, Bylaws, names and addresses of board members, if applicable
- Current CPR and First Aid for Staff (front & back of card)**
- Current Medical Report on each paid staff (recertification: only for staff hired since last recertification)**
- Verification of Statewide Criminal History Check for the past 5 years for new Staff (recertification: only for employees hired since last recertification) by an agency approved by the North Carolina Administrative Offices of the Courts <http://www.nccourts.org>**

Other Attachments, Please Specify

- _____
- _____

SEE REVERSE SIDE FOR INSTRUCTIONS

DAAS-1500 (8/2008)/ Program Operations

Prepare 2 copies: Original to Adult Day Care Consultant, one copy to day care program and one copy for department of social services.

ADULT DAY SERVICES CERTIFICATION REPORT

Instructions for Completion

The Adult Day Services Certification Report is completed by the county department of social services to document whether or not standards are met by the adult day services program. It is submitted with other necessary information to the Adult Day Care Consultant, Division of Aging and Adult Services.

The form is in two parts. The first part, the Face Sheet, contains identifying and general information regarding the adult day services program, the certification action requested and a checklist for necessary information to accompany the form. The Face Sheet must be submitted for all actions regarding certification which are listed on the top of the form. Reference should be made to Section VI of the certification standards manual for information regarding procedures and requirements for all actions concerning certification. **Any change of address (location) of an existing program is to be treated as an initial certification.** Change of capacity requires submission of a floor plan, which identifies sufficient square footage, toilets and furnishings to support the requested capacity. A building inspection report is required if structural modifications have been made to support the increased capacity. A medical report for any new staff members employed to support the capacity increase must also be submitted.

The second part, the Standards Review, is an outline and checklist of the certification standards that must be met by the adult day services program. The Standards Review Section is to be submitted with the Face Sheet for initial certification (including change of address), denial, revocation, and renewal of certification. The Standards Review follows the outline sequence of the certification standards manual. Those items in the certification standards manual that apply only to adult day health or combination adult day care/day health programs are not included in this Standards Review Section. Some parts of the review outline will not be applicable to the adult day care services being reviewed, depending on whether the program is a center or a home. These parts are clearly identified on the form. There is space at the end of each part of the outline which is to be used to comment regarding non-compliance with any standard in that part. The concluding summary should relate to those comments in describing the program's overall performance and recommending action regarding certification. It should be understood that for initial certification of a new program, some areas will be incomplete (for example, participant and program records). In such instances, plans and capability to comply with standards should be reviewed.

After completing the Standards Review, the county department of social services should indicate whether or not certification or recertification is recommended. If the agency does not recommend "Approval of Certification", the appropriate block "Provisional", "Denial", or "Revocation" should be checked and statement of reasons attached.

STANDARDS REVIEW

- I. ADMINISTRATION**
- A. Governing Body**
- | YES | NO | |
|-----|-----|--|
| | | 1. Adult Day Care Center Governing Body: _____
Board of Directors or Owner(s) Auspices Under Which Center Operates |
| | | 2. Governing Body or Operator Carries Out Responsibilities As Specified.
Responsibilities Include: |
| () | () | a. Approval of Organizational Structure (Centers only) |
| () | () | b. Adoption or Development of Annual Budget |
| () | () | c. Regular Review of Financial Status, Including Annual Budget, Monthly Accounts of Income and Expenditures to Reflect Against Budget, and Annual Audit for Centers; or Maintenance of Monthly Accounts of Income and Expenditures for Homes |
| () | () | d. Appointment of Program Director for Centers |
| () | () | e. Establishment of Written Policies Regarding Operation in Direct and Understandable Language which includes: |
| | | <input type="checkbox"/> Program Policies |
| | | <input type="checkbox"/> Personnel Policies |
| | | <input type="checkbox"/> Any other policies deemed necessary, such as arrangement with other agencies and organizations |
| | | B. Program Policies |
| () | () | 1. Program Goals in Writing and Consistent with Definition of Adult Day Care Services |
| () | () | 2. Enrollment Policies in Writing, Define the Population Served and are Specific to Prevent Enrolling People Whose Needs Cannot be Met by the Planned Activities |
| () | () | 3. Program Policies Include the Following |
| () | () | a. Discharge policy outlining criteria for discharge and notification procedures for discharge, the timeframe and procedures for notifying family or responsible person of discharge, and referral or follow-up procedures; |
| () | () | b. Medication policy regarding |
| () | () | Participant Medication Use |
| () | () | Medication Administration Order Changes |
| () | () | Medication Disposal |
| () | () | c. Participant Rights Description |
| () | () | d. Grievance Policies and Procedures for Families |
| () | () | e. Advance Directives Policies |
| () | () | f. Non-Discrimination Policies |
| () | () | g. Procedures to Maintain Confidentiality |
| () | () | h. Reporting Suspected Abuse or Neglect |
| () | () | i. Geographical Area Served by Program |
| () | () | j. Inclement Weather |
| () | () | k. Transportation policy including |
| () | () | Routine and Emergency Procedures |
| () | () | Accidents |
| () | () | Medical Emergencies |
| () | () | Weather Emergencies and Escort Issues |
| () | () | 4. Includes Hours and Days of Operation |
| () | () | 5. Supervision of Adult Day Care Program Participants and Services Provided Throughout All Hours Participants are Present |
| () | () | 6. Program in Operation a Minimum of Six (6) Hours Each Day, Five (5) Days Per Week, with Exceptions Noted |
| () | () | 7. Types of Services are Identified, Including Transportation |

YES NO

C. Personnel Policies

() () Personnel Policies Developed and Shared with Employees, Include Necessary Information and Comply with Wage and Hour Regulations.

D. Insurance

() () Adequate Liability Insurance for Facility and Vehicles.

If NO is checked for any standard under ADMINISTRATION, Please explain and comment as to actions needed and plans for the program to comply.

II. PERSONNEL

List Names and Positions of Paid Staff Members and Volunteers used to maintain adequate staffing ratios

EMPLOYEE NAME	JOB TITLE <i>Indicate here if person is a Volunteer & is used to maintain staffing ratios.</i>	SUBSTITUTE <i>If yes, Check Box. If No, do not check box.</i>	NEW HIRE SINCE LAST RECERTIFICATION <i>If yes, check Box. If No, do not check box.</i>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**** Use Additional Sheet for larger programs****

YES NO

A. General Personnel Requirements

- () () 1. Staff Positions Planned and Filled According to Program Goals and Manpower.
- () () 2. Evidence of a statewide criminal history records search for the last 5 years on employees by an agency approved by the North Carolina Administrative Offices of the Courts hired after July 1, 2007. <http://www.nccourts.org>
- () () 3. Written Job Description for Each Position Containing Required Information. (Standards, Page 5-6).
- () () 4. References Required in Recruitment of Staff.
- () () 5. Established Review Process for Each Employee and Reviews Conducted at Least Annually.
- () () 6. Provision for Orientation and Staff Development of New Employees and Volunteers, and Ongoing Development and Training of All Staff. Such Orientation and Training is Documented.

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Minimum of one Substitute Staff Person With Same Qualifications, Training, and Personal Credentials as Regular Staff is available in the absence of regular staff. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Medical Report on File, Completed Within the Prior 12 Months of Hire Date. |
| | | B. Staffing Patterns |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Staffing Adequate to Meet Program Goals and Objectives. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Written Substitution plan in place to maintain required staffing ratios and has been reviewed (attach copy to report) |
| | | C. Program Director |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Program Has Full-Time Director. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Program Director Has Authority and Responsibility for Program Management. |
| | | 3. Program Director Meets Minimum Qualifications: |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Is At Least 18 Years of Age |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Has Completed a Minimum of 2 Years of Formal Post Secondary Education from an Accrediting Agency Recognized by the US Department of Education or High School Diploma or Equivalent and a Combination Minimum of Five Years of Experience and Training in Services To Elderly or Adults with Disabilities; |
| <input type="checkbox"/> | <input type="checkbox"/> | c. At Least Two Years of Work Experience in Supervision and Administration; |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Medical Report on File, Completed Within the Prior 12 Months of Hire Date. |
| <input type="checkbox"/> | <input type="checkbox"/> | e. At Least 3 Current Reference Letters or the Names of Individuals With Whom a Reference Interview Can Be Conducted, Including at Least One Former Employer. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Governing Body Considered Characteristics Specified in Standards in Employing Director (Standards, page 8). |
| | | D. If Adult Day Care Home, Minimum of One Staff Person During all Hours of Operation Meeting Requirements of Director and Substitute or Relief Staff to Allow the Program to Remain Open on Days When Operator Is Not Available. |
| | | E-G Apply only to Adult Day Health |
| <input type="checkbox"/> | <input type="checkbox"/> | H. Does the Program Use VOLUNTEERS? IF YES: |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Volunteers Have Written Description of Duties and Responsibilities; |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Volunteers Are Provided Orientation and Training to the Program; |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Paid Staff Are Provided Required Information Regarding Volunteers and Are Involved in Writing Volunteer Duties; |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Provision Is Made for Evaluation of Volunteer's Job Performance; and |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Recognition and Appreciation of Volunteers. |

If NO is Checked for Any Standard Under PERSONNEL Please Explain and Comment As to Actions Needed and Plans for the Program to Comply.

- | YES | NO | |
|--------------------------|--------------------------|--|
| | | III. FACILITY |
| | | A. General Requirements |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Certificate from Division of Aging and Adult Services is conspicuously posted in a public place in the facility. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. If current certificate issued by DAAS is Provisional, is it conspicuously posted in a public place in the facility and notice from DAAS identifying reasons for it is posted adjacent to the current certificate. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Facility and Grounds Approved by Local Environmental Health Specialists and Local Fire Safety Inspector, County DSS, and Division of Aging & Adult Services |

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Programs Initially Certified After 1/1/2003 or Those Making Structural Building Modifications Comply with NC Building Code Regulations. If N/A, Check () |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Facility Complies with All Applicable Zoning Laws. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Facility Provides Adaptable Spaces, Which Provide Opportunities for Group Activities and Privacy. |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Facility Provides Minimum 40 Square Feet Per Participant, As Specified in Standards. |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Kitchen Meets Environmental Health Rules, if Meals Prepared on Premises OR meals if meals are catered by a vendor. |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Storage Areas Adequate in Size and Number for Storage of Items Specified in Standards. |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Separate Locked Area Available for Storing Poisons, Chemicals or Other Potentially Harmful Products. |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Minimum of 1 Male and 1 Female Toilet and 1 Toilet for each 12 Adults and 1 Hand Lavatory for Each 2 Toilets. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Rugs and Floor Coverings Securely Fastened, Floors Not Slippery. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Telephone Available as Required. |
| | | B. Applies Only to Adult Day Health |
| | | C. Day Care Programs In Multi-Use Facilities |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Program is Self-Contained with Its Own Staff and Separate Area. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Participation is Open Only to Persons Enrolled in the Program and to Visitors on a Planned Basis. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. When the Program is located in a Multi-Use Facility There Is a Written Agreement Regarding the Facility's Cooperative Use. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Permission by Licensing Agencies to Use Space. If N/A, check () |
| | | D. Building Construction |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Building Meets Approval of Local Building Inspector. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Facility Has Entrance at Ground Level With No Steps or Ramp Which Meets Stated Specifications. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. If Adult Day Health Home, Requirements for Adult Day Health Homes as Specified in Appendix A of Standards are Met. If N/A, check () |
| | | E. Equipment and Furnishings |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Equipment and Furnishings Adequate to Meet The Needs of Participants and Staff |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Facility Has at Least 1 Straight Back or Sturdy Folding Chair for Each Participant and Each Staff Member, Excluding Those in Wheelchairs. |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Table Space Adequate for All Participants to be Served a Meal at a Table at the Same Time, and for Program Activities. |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Chairs or Sofas Allow for Position Changes and are easily cleaned. |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Quiet and Separate Space with Minimum of One Bed or Cot. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. All Equipment and Furnishings in Good Condition and Safe for Use. |

If NO is Checked for Any Standard Under FACILITY, Please Explain and Comment as to Actions Needed and Program Plans to Insure Compliance:

IV. PROGRAM OPERATION

A. Planning Program Activities

1. Enrollment Policies and Procedures

YES NO

- a. Enrollment Determined on the Basis of Enrollment Policies.
- b. Procedures Include A Personal Interview with at Least One Staff Member Prior to Enrollment Including Initial Documentation and Assessment Signed by Staff.
- c. Signed Application Obtained Prior to Attendance as Participant.
- d. Medical Examination Report Completed Within Prior Three Months and Obtained No Later Than Within 30 Days of Enrollment
- e. Program Policies Discussed with Each Applicant and a Copy of the Policy Statement is Given to Each Applicant and to Family or Caretakers.
- f. Documentation of Receipt of and Agreement to Abide by Program Policies by the Participant or Responsible Party Obtained and Kept in Participant's File.
- 2. Planning Services for Individual Participants
 - a. Comprehensive Assessment and Individual Service Plans Developed Within 30 Days of Enrollment, Include Necessary Information and Involving Appropriate Persons, Signed and Dated and Reviewed No Less Than Every Six Months
 - b. Progress Notes Updated at Least Every Three Months
 - c. Participant, Caregiver & Other Service Providers Given Opportunity to Contribute to Development, Implementation and Evaluation of Service Plan
 - d. Changes in Behavior, Attitude, and Problems and Needs for Help Are Reported to Appropriate Person.
 - e. Participants or Responsible Party Involved in Selecting Days to Attend.
 - f. Reason for Any Unscheduled Participant Absences Determined and Documented.
 - g. Participant or Responsible Party Sign Out When Leaving Program During Day.
- 3. Program Activities Plan
 - a. Program Activities Plan Meets the Following Criteria:
 - (1) Based on Elements of Individual Service Plans.
 - (2) Primary Program Mode is Group Process, Both Large and Small Groups, With Provision Made for Individual Activities and Services.
 - (3) Activities are Adaptable and Modifiable
 - (4) Activities are Consistent with Program Goals.
 - (5) Activities are Planned Jointly by Staff and Participants.
 - (6) All Activities are Supervised by Staff.
 - (7) Participants Have Choice of Refusing to Participate in Any Given Activity.
 - b. Program Activities Schedule Provides for the Inclusion of the Following Activities to be Available on Daily Basis:
 - (1) Cognitive
 - (2) Physical
 - (3) Psychosocial
 - c. Activities Schedule
 - (1) In Writing and Specifies the Name, Days of Week, and Approximate Length of Time of Each Activity.
 - (2) Indicates Length of Time the Schedule is to be Followed.
 - (3) Posted Weekly or Monthly in Prominent Place in the Facility
- B. Applies Only to Adult Day Health**
- C. Nutrition**
 - 1. Nutritious Mid-Day Meal Provided to Each Participant As Specified in the Standards (Page 19).
 - 2. Menu Approved by a Registered Dietitian and/or Licensed Nutritionist
 - 3. Snacks and Fluids Offered to Meet Participant's Nutritional and Fluid Needs. At Minimum, Mid-Morning and Mid-Afternoon Snack Offered Daily to Each Participant. Snacks Planned as Specified in Standards.
 - 4. Therapeutic Diet ONLY Provided if Prescribed by Physician, Physicians' Assistant, or Nurse Practitioner for Any Participant.
 - 5. If Therapeutic Diets are Prepared by Program Staff, Such Staff Have Necessary Training. If program contracts with food vendor, check ()

YES NO

- 6. Registered Dietitian or Certified Nutritionist Gives Consultation to Staff on Basic and Special Nutritional Needs, Proper Food Handling and Prevention of Food borne Illness.
- 7. Program Neither Admits Nor Continues to Serve Participants Whose Dietary Needs Cannot Be Accommodated.
- 8. Meals Stored, Prepared and Served in Sanitary Manner Using Safe Food Handling Techniques
- 9. Food Service Provider Abides by Food Safety & Sanitation Practices
- 10. If program contracts with a vendor for Mid-Day Meal and/or Snacks, a current contract is in place, signed and indicates what services vendor will provide (such as: in addition to food, vendor will have Registered Dietician and/or Licensed Nutritionist; approve menus; provide consultation about food-borne illness; Proper Food Handling; Basic & Special Nutritional Needs)

Transportation – *If program does not provide or arrange check here ()*

- 1. Programs Providing or Arranging for Transportation Have Policy As Follows:
 - a. Includes Routine and Emergency Procedures
 - b. Copy of Relevant Procedures Located in All Vehicles
 - c. Accidents, Medical Emergencies and Escort Issues Addressed
 - d. If program arranges transportation, review contract with transportation vendor to ensure that the above standards are required to be met by the transportation vendor.
- 2. When Program Provides Transportation, The Following Requirements Are Met
 - a. Each Person Transported Has Seat in Vehicle.
 - b. Participants Offered Opportunity for Rest Stop At Least Every 30 Minutes.
 - c. Vehicles Used for Transportation Equipped With Seatbelts.
 - d. Vehicles Equipped With First Aid Kit and Fire Extinguisher
- E. Emergencies and First Aid**
 - 1. Approved Fire Safety and Evacuation Plan
 - 2. Plan for Emergencies:
 - a. In Writing and Prominently Displayed in Facility.
 - b. Plan Relates to Medical and Non-Medical Emergencies and Specifies Responsibilities of Each Staff Person.
 - c. All Staff Knowledgeable about Plan.
 - d. Responsibilities of Each Staff Member Identified
 - e. Quarterly Drills in Handling Different Types of Emergencies are Conducted and Documented as to Date and Kind of Emergency.
 - 3. Evacuation Plan Posted in Each Room and Fire Drills Conducted at Least Monthly (for programs without a sprinkler system) or Quarterly (for programs with a sprinkler system).
 - 4. All Physically Able Staff With Direct Participant Contact Have Training in Standard First Aid and Cardio-Pulmonary Resuscitation. Training is Current as Determined by the Organization Conducting the Training and Issuing the Certification.
 - 5. Staff Determined Physically Unable to Complete First Aid or CPR Training Have Medical Statement on File
 - 6. Arrangements Made for Emergency Medical Assistance.
 - 7. Portable Basic Emergency File on Each Participant Is Complete
 - 8. Accidents Taken in Case of Sickness and Related Incidents Reported to Program Director, Family or Responsible Party Notified and Report Sent to DSS
- F. Medications**
 - 1. Medications Administered According to the Participant's Established Medication Schedule or For Non-Prescription Medications, as Authorized by the Participant's Caregiver.
 - 2. A Record of All Medications Given to each Participant is Kept Indicating each Dose and Other Required Information.
 - 3. Medication Record Has Been Updated at Least Once Every Three Months

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Medications Are Kept In Original Pharmacy Containers In Which They were Dispensed. The Containers are Clearly Labeled with the Required Information. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Medications Kept By The Program Are Kept Locked in a Safe Place. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Program Does Not Serve Participants Who Require Intravenous, Intramuscular or Subcutaneous Medications |
| | | G. Program Evaluation |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Plan for Evaluation of Operation and Services in Writing and Includes Required Information. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Formal Evaluation Conducted at Regular Intervals, at Least Annually. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Specified Parties Involved, as Appropriate, In Evaluation Process. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Evaluation Focuses on Required Areas. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Written Report of Evaluation on File. |

If NO is Checked for Any Standard Under PROGRAM OPERATION, Please Explain and Comment as to Action Needed and Program Plans to Comply.

- | YES | NO | |
|--------------------------|--------------------------|---|
| | | V. RECORDS |
| | | A. Individual Participant Records |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Individual Folder is Established and Maintained for Each Participant, Including: |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Signed Application, Including: |
| <input type="checkbox"/> | <input type="checkbox"/> | (1) Participant's Full Name. |
| <input type="checkbox"/> | <input type="checkbox"/> | (2) Address and Telephone Number. |
| <input type="checkbox"/> | <input type="checkbox"/> | (3) Date of Birth, Marital Status, and Living Arrangement. |
| <input type="checkbox"/> | <input type="checkbox"/> | (4) Time of Day Participant Will Arrive and Leave. |
| <input type="checkbox"/> | <input type="checkbox"/> | (5) Travel Arrangements To and From The Program |
| <input type="checkbox"/> | <input type="checkbox"/> | (6) Name, Address, and Phone Number of at Least 2 Family Members or Friends. |
| <input type="checkbox"/> | <input type="checkbox"/> | (7) Name, Address, and Phone Number of the Individual's Licensed Medical Service Provider. |
| <input type="checkbox"/> | <input type="checkbox"/> | (8) Personal Concerns and Knowledge of the Caregiver That May Affect Care Plan |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Copies of All Current and Former Signed Authorizations to Receive and Give Out Confidential Information, Dated Within Prior 12 Months and Obtained Each Time Request for Information Is Made From a Different Party. |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Signed Authorization for Emergency Medical Care. |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Signed Medical Report Completed Within Prior Three Months of Enrollment and Updated Annually Thereafter; The Report Includes Information On: |
| <input type="checkbox"/> | <input type="checkbox"/> | (1) Current Diseases and Chronic Conditions and Extent to Which They Require Observation by Staff and Restriction of Activities by Participant; |
| <input type="checkbox"/> | <input type="checkbox"/> | (2) Presence and Degree of Psychiatric Problems; |
| <input type="checkbox"/> | <input type="checkbox"/> | (3) Amount of Direct Supervision Required; |
| <input type="checkbox"/> | <input type="checkbox"/> | (4) Any Limitations on Physical Activities; |
| <input type="checkbox"/> | <input type="checkbox"/> | (5) Listing of All Medications With Dosages and Times to be Administered; |
| <input type="checkbox"/> | <input type="checkbox"/> | (6) Most Recent Date Participant Seen by Doctor. |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Initial and Comprehensive Assessment Forms |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Progress Notes: Reports of Staff Discussions, Conferences, Consultation with Family or Other Parties, Evaluation of Progress, & Other Significant Information. |

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | g. All Service Plans for The Participants, Including Schedules Days of Attendance for the Previous 12 Months. |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Signed Authorizations Re. Photographs, Video & Audio Recordings |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Signed Documentation by Responsible Party of Receipt of and Agreement to Abide by Program Policies on File |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Individual Folders Are Kept in Locked File |
| | | B. Records |
| | | Records Kept a Minimum of Six (6) Years [per DHHS Records and Retention Schedule dated 1/2007: reference 09NCAC 03M .0703(4)] and Contain: |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Copies of Activities Schedules. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Monthly Records of Expense and Income. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. All Bills, Receipts, and Other Documentation of Expenses and Income. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Daily Record of Attendance of Participants by Name. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Accident Reports. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Record of Staff Absences, Annual Leave and Sick Leave, with Dates and Names of Substitutes. If operator only staff, check N/A () |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Reports on Emergency and Fire Drills. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Individual Personnel Records on All Staff, Including Required Information. If operator only staff, check N/A () |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Copy of All Written Policies, As Required. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Program Evaluation Reports. |

If NO is Checked for Any Standard under RECORDS, Please Explain and Comment As to Action Needed and Program Plans to Comply.

**** PART ONE OF SPECIAL CARE SERVICES ON THE FOLLOWING PAGE MUST BE COMPLETED FOR ALL PROGRAMS ****

Do Not Skip This Section

Part 1 of Special Care Services MUST BE COMPLETED on ALL PROGRAMS

YES NO

VI. SPECIAL CARE SERVICES (Part 1)

A. Screening For Special Care Services (All Renewal Or New Certifications Must Complete And Submit This Section)

- | | | | |
|-----|-----|----|---|
| () | () | 1. | The Program's Name Includes or Mentions a Disease, Condition or Disability Group. |
| () | () | 2. | In the Program Policy Statement or the Program Brochure, the Program Advertises, Claims or Markets Special Care Services by Name for Any Disease, Condition or Disability Group. |
| () | () | 3. | Program Goals Refer to Specialized Services or Care for Persons with Certain Conditions or Disabilities. |
| () | () | 4. | Enrollment Policies Target or Mention Specialized Care for Persons with Alzheimer's Disease or Other Dementia, Developmental Disabilities, Persons with HIV-AIDS or Other Special Conditions or Disabilities. |
| () | () | 5. | Brochures, Pamphlets, Posters or Other Outreach or Publicity Material Reference Special Care or Special Programming for Persons With: |
| () | () | | Alzheimer's Disease or Other Dementia |
| () | () | | Developmental Disabilities |
| () | () | | Parkinson's Disease |
| () | () | | HIV-AIDS |
| () | () | | Others: Specify _____ |
| () | () | 6. | Brochures or Pamphlets Refer to Care for Persons with a Special Disability or Condition by Separate Programming. |
| | | 7. | If "Yes" Is Checked In Any Of The Above, Determine That: |
| () | () | a. | The Program Provides Specialized Care for One or More of the Above Groups, OR |
| () | () | b. | The Program Does Not Provide Specialized Care. |
| | | | If 7b Above Is Checked, Part 2 Does Not Need To Be Completed. |
| | | | If 7a Above Is Checked, Complete Part 2 (Specialized Care). |
| | | | Program Policies and Implementation for the Special Care Group Includes the Following: |
| | | 1. | The Statement of Mission and Objectives For Special Care Addresses: |
| () | () | a. | Environmental Safety and Appropriateness |
| () | () | b. | Type and Frequency of Daily Activities With Regard to Specialized Service |
| () | () | c. | Service Plans that Emphasize Capacities as Well as Deficits |
| () | () | d. | Methods of Behavior Management Which Preserve Dignity Through Design of Physical Environment, Physical and Social Activity, Appropriate Medication Administration, Proper Nutrition and Health Maintenance. |
| () | () | 2. | Process and Criteria for Enrollment and Discharge From Special Care. |
| () | () | 3. | The Policies Describe Accurately the Special Care Services in the Center. |
| () | () | 4. | Participant Assessment and Service Planning Includes Opportunity for Family Involvement in Planning and Implementation of the Service Plan, AND Participant Assessment and Service Planning Provides for Appropriate Response to Changes in the Participant's Condition. |
| () | () | 5. | Safety Measures Address Specific Dangers Such as Wandering, Ingestion, Falls, Smoking, and Aggressive Behavior. |
| () | () | 6. | Emergency Procedures Address Possible Lost or Missing Participants. |
| () | () | 7. | The Specialized Service is Staffed to Meet the Needs of Participants. |
| () | () | 8. | The Staff Annually Receives Training in Specialized Care for the Population. |
| () | () | 9. | Physical Environment and Design Features Address the Needs of the Special Care Population. |
| () | () | a. | Locking Devices (If Used In Program) Meet Requirements in N.C. State Building Code for Locking Devices. |

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | b. If Program Does Not Have Locked Doors, a System of Security Monitoring is Provided. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Activities Offer Options Depending on Personal Preferences and Abilities of Participants. |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. The Program Offers Involvement for Family/Caregivers. |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. The Program Keeps and Disseminates Current Information on Family Support Groups and Other Resources for the Special Population. |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Enrollment Policies Disclose Additional Costs of Special Care Services and Ancillary Services Available, if Applicable. |
| | | Care Includes: |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Participants Receiving Special Care Have Access to an Outside Area. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. The Outside Area is Secured or Supervised if Participants Have Impairments That Would Compromise Safety. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Disclosure Information Provided at Enrollment. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Participant Meets Criteria for Special Population: Health Professional Documentation. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. If DD Participant, Has Been Through Single Portal. If N/A Check () |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Service Plans Based on Participants' Needs, Interests and Abilities. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Service Plans Demonstrate a Balance of Activities, Optimum Functioning and Activities of Daily Living. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. If Participant is Transferred From Standard Adult Day Care to Special Care, Family or Responsible Person Agrees to Transfer. |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Service Plans Involve Environmental, Social and Health Care Strategies to Help Participants Attain or Maintain Their Maximum Level of Ability. |
| | | Staff Orientation And Training |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Program Director Has Had Prior Specialized Training. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Written Plan for Training Staff Identifies Content, Sources, Schedules of Training: Annual Update. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Within 1 Month of Employment, Each Staff Person Assigned to Special Care Service Demonstrates Knowledge of Needs, Levels of Ability and Interests of Participants. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Within 6 Months of Employment, Each Staff Person has Completed 3 Training Experiences. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Each Direct Care Staff Completes 2 Population Specific Trainings Annually. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. All Training Experiences Documented in Center's Files. |
| | | If Center Has A Special Care Services Unit: |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Unit is Separated By Closed Doors and Not a Pass Through Area. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Unit Has Furnishings and Equipment Required for Number of Unit Participants. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Unit Has at Least One Toilet. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Unit Has Space Per Participant Required in Standards. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Unit Has Participant/Staff Ratio Required in Standards. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Participants Receiving Special Care Have Access to an Outside Area. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. The Outside Area is Secured or Supervised if Participants Have Impairments That Would Compromise Safety. |

If NO is Checked for Any Standards Under SPECIAL CARE SERVICES PART 2, Please Explain and Comment Regarding Actions Needed and Program Plans to Insure Compliance:

SUMMARY AND CONCLUSION (Use This Space for Evaluation of the Adult Day Care Program's Overall Service Delivery; Services and Activities Considered to be Exemplary; Any Information You Believe to Be Significant Which Is Not Included Elsewhere in This Report.)

The County Department of Social Services Recommends:

- () APPROVAL OF CERTIFICATION () PROVISIONAL CERTIFICATION
() DENIAL OF CERTIFICATION () REVOCATION OF EXISTING CERTIFICATION

If Provisional, Denial, or Revocation is Recommended, Please use a Separate Sheet of Paper for Statement of Reasons for Recommendation, Including Standards Which Have Been Violated and Factual Account of Actions Taken in Attempts to Correct Violations.

County Adult Day Care Coordinator

Date: _____

County Director of Social Services

Date: _____

Day Care Program Director or Operator

Date: _____

County Department of Social Services