

<b>MONITORING REPORT</b> <b>ADULT DAY CARE AND ADULT DAY HEALTH</b>
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DATE OF VISIT: \_\_\_\_\_

- I. PROGRAM: \_\_\_\_\_ COUNTY: \_\_\_\_\_
- II. TYPE OF PROGRAM:  ADC  ADH  ADC/ADH
- III. TYPE OF VISIT: ( ) Announced ( ) Unannounced TIME OF VISIT: \_\_\_\_\_
- IV. ENROLLMENT: # Full-time \_\_\_\_ # Part-Time \_\_\_\_ Month Reviewed \_\_\_\_\_
- ATTENDANCE: # Participants at time of visit \_\_\_\_ # of Staff at time of visit \_\_\_\_\_
- V. CONCERNS FROM PREVIOUS VISIT: \_\_\_\_\_

Have these concerns been resolved? ( ) YES ( ) NO (If no, complete DSS Form 6215)

VI. AREA REVIEWED:

<b>Medications</b> [10A NCAC 06R .0505 and 06S .0401] – <u>Standards</u> , Pages 22-23
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Yes  No 

- ( ) ( ) The program has a written policy on participant medication use, medication administration order changes and medical disposal.
- ( ) ( ) Medications are administered according to the participant's established medication schedule as determined on the participant's medical examination report or as authorized by the responsible caregiver.
- ( ) ( ) A record of medications given to each participant is kept and updated a minimum of once every quarter.
- ( ) ( ) The participant's medication record includes the following:
- Participant's name;
  - Name, strength, quantity and route of the medication;
  - Instructions for giving the medication;
  - Date and time medication is administered; and
  - Name or initials of person giving the medication. If initials are used, a signature equivalent to those initials is entered on this record.
- ( ) ( ) Medications are in the containers in which they were dispensed
- ( ) ( ) Containers are clearly labeled with the participant's full name, the name and strength of the medication, dosage, and instructions for giving the medication.
- ( ) ( ) Medications are kept in a locked location
- ( ) ( ) Day care only programs have not enrolled or do not serve participants who require intravenous, intramuscular or subcutaneous medications while attending the program. Check here if N/A ( )

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Make copies for DSS file; Program Director, and State Adult Day Services Consultant.

DAAS-6214 (7-07)

Check Yes or No. If no, provide explanation.

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**Medications (Continued)**

VII. COMMENTS/CONCERNS \_\_\_\_\_  
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*Attach an additional sheet if needed*

VIII. PROGRAM DIRECTOR'S COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IX. Continued by ( ) DSS-6215 ( \_\_\_\_ # of forms)

X. Signatures:

\_\_\_\_\_  
Coordinator and/or Specialist      Date      Program Director      Date