

**MONITORING REPORT
ADULT DAY CARE AND ADULT DAY HEALTH**

DATE OF VISIT: _____

I. PROGRAM: _____ COUNTY: _____

II. TYPE OF VISIT: () Announced () Unannounced TIME OF VISIT: _____

III. ENROLLMENT: # Full-time ____ # Part-Time ____ Month Reviewed _____
ATTENDANCE: # Participants at time of visit ____ # of Staff _____

IV. CONCERNS FROM PREVIOUS VISIT: _____

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

V. AREA REVIEWED:

Medications [10A NCAC 06R .0505 and 06S .0401] – Standards, Pages 22-23

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.

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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)

VI. COMMENTS/CONCERNS _____

Attach an additional sheet if needed

VII. PROGRAM DIRECTOR'S COMMENTS _____

VIII. Continued by () DSS-6215 (____ # of forms)

IX. Signatures:

Coordinator and/or Specialist	Date	Program Director	Date
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