

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

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:

Nutrition [10A NCAC 06R .0502 and 06S .0401] – <u>Standards</u> , Pages 19-20
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Yes No

- () () Midday meal which provides at least one-third (1/3) of an adult's daily nutritional requirement is provided each participant in attendance.
- () () Menu is approved by a registered or licensed dietitian or nutritionist.
- () () Snacks and fluids are offered to meet participants nutritional and fluid needs.
- () () At minimum mid-morning and mid-afternoon snack is offered daily to participants and is planned to keep sugar, salt and cholesterol intake to a minimum.
- () () Therapeutic diets are provided, if prescribed in writing by a physician, physician's assistant or nurse practitioner.
- () () Staff preparing therapeutic diets have necessary training and adequate documentation of such training.
- () () Registered dietitian or certified nutritionist gives consultation to staff on basic and special nutritional needs, proper food handling techniques, and the prevention of food borne illness.
- () () The program does not admit nor continues to serve participants whose dietary requirements cannot be accommodated by the program.
- () () Meals are stored, prepared and served in a sanitary manner using safe food handling techniques.
- () () The food service provider abides by the food safety and sanitation practices required by the Commission for Health Services rules applying to adult day care facilities.

VII. COMMENTS/CONCERNS _____

VIII. PROGRAM DIRECTOR'S COMMENTS: Attach an additional sheet

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

X. Signatures:

Coordinator_____
Date_____
Program Director_____
Date

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.