|  |
| --- |
| **Aurora Adult Day Care LLC** |
| **Address: 1330 South Potomac St, Suite #116, Aurora, CO - 80012** |
| **Ph: 720-484-5770 Fax: 720-4597550** |

**Intake/ Admission Date: \_\_\_\_\_\_\_\_\_**

**Participants Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: M F Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_**

**State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medicaid documentation of the ULTC-100.2MedicaidNumber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Typical Behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical Limitations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Food Dislikes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special Needs: (toileting, ambulation, transferring etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Activity Preferences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service Goals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

Consumer Admission

Only consumers whose needs can be met by the Adult Day Services Center within its certification category and population served shall be admitted to the Center.

1. Adult Day Care Centers are classified as follows:

* Basic Adult Day Services (ADS) is a community-based entity.
* Specialized Adult Day Services (SADS) designated when the Center has 2/3 of the consumer population have the following conditions.
	+ Consumers must have a confirmed diagnosis of Alzheimer’s and related disorders, multiple sclerosis, brain injury, chronic mental illness. Post stroke consumers who require extensive rehabilitative therapies.

2. For Medicaid consumers, the case manager must forward the most recent copy of the Participants ULTC-100.2 to the Facility as documentation of diagnosis that supports the consumers need for SADS.

3. Admission Documentation

* Diagnosis verification either with the ULTC-100.2 or for other consumers the diagnosis and recommended specialized services are documented in the care plan and verified by the consumers physician. Documentation must be verified at the time of admission and with any significant change in condition.
* Documentation of interview information prior to admission to determine the consumers level of function and activities and nutrition requirements and development of the consumer care plan.
* Documentation that the consumer and/or other responsible party was provided with written information about his/her rights under the state law regarding advanced directives. (The Facility utilizes the MOST form)
* Documentation of whether the consumer has executed any advanced directives or declarations.

4. Consumer records contain:

* Name, address, sex and age of each consumer
* Documentation concerning advanced directives.
* Name, address and telephone number of responsible parties
* Name, address and telephone number and fax of primary physician
* Documentation of supervision and monitoring of the services provided.
* Documentation of orientation to the facility and the policies and procedures for the consumer and responsible party
* Name, address and phone number of the case manager and single-entry point agency
* Signed service agreement.
	+ Agreed upon days and times of service and payment
	+ Start of service date
* Individualized care plan

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Services Agreement

I would like to be a participant in Adult Day Program. I have received an explanation of the services that will be provided to me, a facility tour, and understand that I have the right to participate in activities of my choosing.

Agreed Upon Days and Times of Attendance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization for Release of Information

I hereby consent and authorize the Agency to release and receive information for the purposes of treatment, payment, and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health providers, and regulatory and/or accrediting reviewers.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Statement to Permit Payment for Home Health Services

I hereby request that payment of authorized adult day program services be made on my behalf to the Agency.

I understand that agency will bill MedicaidPrivate PayInsurance Co.:

Patient for the services being provided to me by the Agency. I understand that I will be responsible for the following amount:

Acknowledgements

I have received verbal and written information on the following, and have had the information explained to me:

1. Participant Handbook

Facility rules

1. Emergency Preparedness, Infection Control and Safety Education
2. Facility Tour
3. Orientation to policy and procedures

Advance Directives

I have an Advance Directive Yes No

If yes, I have the following Living Will Medical Durable Power of Attorney Do Not Resuscitate Order

Other Advanced Directives Yes No Explain

Copy obtained Yes No Name and phone number of MDPOA

I would like more information on Advanced Directives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and agree with the information on this document and have been provided a copy for my records. I have participated in the formation of my plan of care.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature or responsible party Date**

**Staff Signature Date**

**Facility Rules**

The following rules are provided to all participants and their caregivers, staff, and posted in our facility:

* No weapons are allowed.
* No foul language
* No violence
* All medications are to be kept in the facility medication center.
* All people entering the facility must sign in.
* Participants may not leave the facility without permission and staff knowledge.
* No smoking in the facility
* No use of restraints

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Use of Restraints**

**INVOLUNTARY RESTRAINT**

1. Definitions

a. Chemical restraint means giving an individual medication involuntarily for the purpose of restraining that individual; except that chemical restrain does not include the involuntary administration of medication pursuant to Section 27-65-111(5), C.R.S. or administration of medication for voluntary or life-saving medical procedures.

b. Emergency means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm.

c. Mechanical restraint means a physical device used to involuntarily restrict the movement of an individual or the movement or normal function of a portion of his or her body.

d. Physical restraint means the use of bodily, physical force to involuntarily limit an individual’s freedom of movement; except that “physical restraint’ does not include the holding of a child by one adult for the purposes of calming or comforting the child.

e. Restraint means any method or device used to involuntarily limit freedom of movement, including but not limited to bodily physical force, mechanical devices, or chemicals. Restraint includes a chemical restraint, mechanical restraint, physical restraint, and seclusion.

f. Seclusion means the placement of a person alone in a room from which egress is involuntarily prevented.

2. Exemptions

 Restraint does not include:

a. The use of protective devices or adaptive devices for providing physical support, prevention of injury, or voluntary or life-saving medical procedures.

b. The holding or an individual for less than five (5) minutes by a staff person for protection of the individual or other persons.

 c. Placement of an inpatient or resident in his or her room for the night.

d. The use of time-out as may be defined by written policies, rules, or procedures of a facility;

 e. Restraints used while the facility is engaged in transporting a person from one facility or location to another facility or location when it is within the scope of that facilities powers and authority to effect such transportation.

3. Basis for use of restraint

 a. A facility may only use restraint:

In cases of emergency and after the failure of less restrictive alternatives or after a determination that such alternatives would be inappropriate or ineffective under the circumstances.

b. A facility that uses restraint pursuant to the provisions of subsection (1) of this section shall use such restraint:

* For the purpose of preventing the continuation or renewal of an emergency
* For the period of time necessary to accomplish its purpose and
* In the case of physical restraint, using no more force than is necessary to limit the individual’s freedom of movement

4. Duties relating to use of restraint

 a. Our facility shall ensure that:

* No physical of an individual shall place excess pressure on the chest or back or that individual or inhibit or impede the individual’s ability to breathe.
* During physical restraint of an individual, an agent or employee of the facility shall check to ensure that the breathing of the individual in such physical restraint is not compromised.
* An individual in physical restraint shall be released from such restraint within fifteen minutes after the initiation of physical restraint, except when precluded for safety reasons.

b. Our facility assures that staff utilizing restraint in our facility are trained in the appropriate use of restraint and are re-trained annually or as often as new training is utilized.

c. Appropriate documentation following the use of physical restraints shall include the following and be placed in the patient record and in an incident report:

* Details of the incident that lead to the use of the restraint.
* Type of restraint and length of time utilized.
* Identification of staff involved in the initiation of the restraint.
* Care provided to the resident after the restraint is released.
* The effect of the restraint on the individual and on the situation

A review of the use of the restraint to assure appropriate use and resolution if not appropriate.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### **Incident/Occurrence Reporting**

1. An *Incident/Occurrence Report: Consumer or Employee* will be completed on all incidents, as defined in policy, by the staff member involved or the first person to become aware of the incident.
2. The report will be submitted to the Facility Director, who is responsible for immediate investigation of the incident and taking any appropriate action, including instituting appropriate measures to prevent similar future occurrences.
3. The Facility Director will review the *Incident/Occurrence Report: Consumer or Employee* and will document awareness of the incident, adding it to the incident log.
4. The Facility Director will determine the appropriateness of reporting the occurrence to the CDPHE and will ensure compliance with all reporting requirements of 6 CCR 1011-1, Chapter 2, section 3.2.
* Documentation regarding the investigation, including appropriate measures to be instituted, shall be made available to the CDPHE, upon request.
* A report with the investigation findings shall be available for review by the CDPHE within five (5) working days of occurrence.
	+ The Facility shall ensure that all staff have knowledge of Article 3.1 of Title 26, C.R.S. regarding protective services for at-risk adults, and that all incidents involving neglect, abuse or financial exploitation are reported immediately, through established procedures, to the Facility Administrator or manager.
		- The Facility shall report the incident to the appropriate officials as specified in the statute and, if applicable, to the CDPHE as an occurrence. The facility shall make copies of all such reports available to the department upon request.
		- The Facility shall document that all alleged incidents involving neglect, abuse or health professional misconduct are thoroughly investigated in a timely manner.
1. The Facility will continue to provide the consumer with the care agreed upon in the service agreement during the investigation, unless the consumer or consumer’s representative requests discontinuation of services, or if continuation of services would place the consumer or employee at risk.
2. The supervisor will assure all applicable federal/state reports/forms are completed, e.g., OSHA 300 Log, as needed.
3. The Incident/Occurrence binder will be maintained with the incident reports and the incident log. Quarterly, the log will be reviewed, and any trends identified will be documented on the quarterly audit performance plan.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Procedure**

1. The facility will develop an emergency plan that supports the facility:

* During an emergency that requires the facility to evacuate the building
* During a consumer of staff member medical emergency
* If the Facility has an intruder that intends to cause harm

2. The facility will conduct a fire drill annually

3. The facility will conduct an emergency drill annually

4. Exit evacuation plans are posted in each room

5. A first aid kit is in the facility

6. In the event of a medical accident, the facility personal will follow the posted protocol

7. Staff will be trained to be alert for potential hazards to include but not limited to:

* Wet spots in the floor
* Consumer equipment (wheelchairs, walkers, oxygen etc.)
* Items that could cause a fall.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Consumer Admission

Only consumers whose needs can be met by the Adult Day Services Center within its certification category and population served shall be admitted to the Center.

1. Adult Day Care Centers are classified as follows:

* Basic Adult Day Services (ADS) is a community-based entity.
* Specialized Adult Day Services (SADS) designated when the Center has 2/3 of the consumer population have the following conditions.
	+ Consumers must have a confirmed diagnosis of Alzheimer’s and related disorders, multiple sclerosis, brain injury, chronic mental illness. Post stroke consumers who require extensive rehabilitative therapies.

2. For Medicaid consumers, the case manager must forward the most recent copy of the Participants ULTC-100.2 to the Facility as documentation of diagnosis that supports the consumers need for SADS.

3. Admission Documentation

* Diagnosis verification either with the ULTC-100.2 or for other consumers the diagnosis and recommended specialized services are documented in the care plan and verified by the consumers physician. Documentation must be verified at the time of admission and with any significant change in condition.
* Documentation of interview information prior to admission to determine the consumers level of function and activities and nutrition requirements and development of the consumer care plan.
* Documentation that the consumer and/or other responsible party was provided with written information about his/her rights under the state law regarding advanced directives. (The Facility utilizes the MOST form)
* Documentation of whether the consumer has executed any advanced directives or declarations.

4. Consumer records contain:

* Name, address, sex, and age of each consumer
* Documentation concerning advanced directives.
* Name, address, and telephone number of responsible parties
* Name, address and telephone number and fax of primary physician
* Documentation of supervision and monitoring of the services provided.
* Documentation of orientation to the facility and the policies and procedures for the consumer and responsible party
* Name, address and phone number of the case manager and single-entry point agency (if applicable)
* Signed service agreement.
	+ Agreed upon days and times of service and payment.
	+ Start of service date.
* Individualized care plan

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**