Jacobson Memorial Hospital Care Center & Clinics
Peace of Mind. Close to Home.

# ADULT DAY CARE PROGRAM

DEFINITION:

Adult Day Care is a program where participants come to a facility on a daytime basis and return to their home for the night. It is designed for individuals who may have limited physical and psychological needs but are living within their own home setting. These persons may not need nor care to live in an institution on a permanent basis.

PURPOSE:

The intent of Adult Day Care is to make life more meaningful for the individual as they are given the opportunity to function in a social way with other persons while maintaining their present environment.

The program also allows the care giver the opportunity to pursue daytime activities and release some of the responsibility of providing care at home.

SERVICES PROVIDED:

Adult Day Care is provided by qualified staff five days a week, Monday - Friday, from 8 a.m. to 5p.m., or as mutually agreed upon by both parties, in the areas of:

- Assistance with personal care and daily living functions.
- Meals and snacks will be provided.
- Environmental support and safety.
- Assistance with medication administration and treatments as needed.
- Recreational activities.
- Supervised rest periods.

ADMISSION TO ADULT DAY CARE PROGRAM:

- Adult Day Care referral can be made by any interested party.
- The determining factor in any referral is the specific need of individual.
- Any referral for Adult Day Care will go to the Social Service Designee or his/her designee.

RECORDS USED:

* Application/Assessment for admission.
* Plan of Care.
* Admission Agreement
* Recent (within one year) History and Physical.
* Medication Reconciliation Form.

One Adult Day Care record will be maintained during the clients participation in the program. Closed records will be kept in Medical Records department for a minimum of 3 years.

## ADULT DAY CARE POLICIES AND PROCEDURES

1. Any referral for adult day care will go to the Social Service Designee or designee in his/her absence.

2. An individual can participate in adult day care according to their needs, from one to five days a week.

3. An individual requesting day care must initially go through the complete application process.Drop-ins will not be accepted.

4. Meals and snacks will be provided.

5. Group activities will be provided in the nursing facility unit.

6. Adult day care clients shall bring their own medications, supplies, equipment and personal care items. Any item supplied by the facility will be billed for separately.

7. A medication record will be used on every client when licensed staff administers medication.

8. An area allowing privacy for rest periods will be provided.

9. Jacobson Memorial Hospital Care Center reserves the right to refuse acceptance of adult day care clients based on facility census and criteria. Clients must be free from communicable disease.

10. All clients who are not COVID-19 vaccinated must have a PCR COVID-19 test with a negative result with-in 24 hours prior to start of services and weekly thereafter. All results will be given to the facility.

11. A History and Physical (at least once a year) stating the individual's health status shall be given by the client'sphysician.

12. Orders for any special diet, treatment, or prescription medicine for the client shall be signed by the physician.

13. A flow sheet will be used on every adult day care client to record attendance, activities, treatments, ADL's and other pertinent information.

14. The adult day care program functions five days a week, Monday - Friday, 8 a.m. to 5 p.m., or as mutually agreed upon by both parties. Clients will return to their homes each night.

15. Adult day care services will be charged on a per diem basis.

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**ADULT DAY CARE SERVICES**
**CLIENT OBLIGATION**

FINANCIAL:

The obligation to reimburse the facility for the Adult Day Care services provided lies with the client or responsible party. Financial arrangements to be made with the Business Office in advance. The current daily rate is $13.50 per hour. Adult Day Care is not currently covered under Medicare.

MEDICATIONS AND SUPPLIES:

The client isresponsible for providing the facility with medications needed, any special supplies, equipment, and personal care items.

RESPONSIBILITY:

The client is responsible for obtaining a medical examination by a licensed physician and a signed statement of the condition of health. The facility has the right to terminate the stay of Adult Day Care participants. The facility does not encourage valuables to be brought into the facility and takes no responsibility for such items.

EMERGENCY CARE:

The clients primary care giver shall leave a number whereby they can be reached in an emergency. The facility will use every reasonable means to protect life and limb of this person and will use the appropriate safety measures to avoid accidents. In case of a medical emergency, I hereby authorize Jacobson Memorial Hospital Care Center to take whatever emergency measures it deems necessary. I hereby release the Jacobson Memorial Hospital Care Center from all liability for accident or injury.

I HAVE READ AND UNDERSTAND the requirements for participating in the Jacobson Memorial Hospital Care Center's Adult Day Care Program.

_____
Client and/or Responsible Party

_____
Relationship to client

_____
Signature of Witness

_____
Date

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# Adult Day Care Application

Applicant Name _____ Date of Birth _____ Age _____ Sex M F

Address _____

Phone _____ Social Security # _____ Religion _____

Marital Status (circle) Married Single Divorced Widowed Name of Spouse (if living) _____

With whom does the applicant live? _____ Relationship _____

Emergency contact _____ Phone _____

Alternate emergency contact _____ Phone _____

List any major operations, chronic illnesses, and medical conditions

_____

_____

_____

Personal Physician _____ Phone _____

Address _____

Preferred hospital _____ Pharmacy _____

What additional special needs does the applicant have? (i.e., need for socialization, supervision, etc.)

_____

Requested starting date _____ Days: (circle) Monday Tuesday Wednesday Thursday Friday

Transported by _____ Any assistance needed _____

Individual or agency responsible for payment

Name_____ Phone number _____

Address _____

Applicant signature _____ Date _____

Signature of person completing application _____ Date _____

Return completed application to:

JMHCC
Attention: Social Services
PO Box 367 Elgin, ND 58533
701.584.2792

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# Adult Day Care
# Plan of Care

Name: _____ Emergency Contact: _____

Code Status: _____ Phone Number: _____

Physician: _____

## Bowel and Bladder

___ Continent ___ Incontinent

___ Bowel ___ Bladder If so, wears incontinent product:

___ Catheter/Foley _____

## Transfer/Mobility

___ Ambulates per self ___ Needs assistance

___ Assistive device

___ Walker ___ Cane ___ Wheelchair

## Fall Risk

___ Hight ___ Medium ___ Low

Date of last fall: _____

## Cognition

___ Alert ___ Oriented (X____) ___ Confused ___ Able to follow directions

Communication

___ Verbal ___ Non-verbal ___ Assistive devices

___ Glasses ___ Hearing Aids (Left / Right)

## Behaviors

___ Wanders ___ Disruptive ___ Hallucinates ___ Verbal / Physical

(over)

## Feeding

Diet: _____

___ Needs set up ___ Feeds self ___ Tube feeding

___ Dentures (Upper / Lower) ___ Own teeth (any missing _____)

## Dressing

___ Needs help ___ Independent

## Protective Devices

___ Hand splints ___ Heel protectors ___ Positioning schedule

___ Special chair ___ Floor mat

## Infection

___ No ___ Yes Type: _____ Antibiotics: _____

Dose: _____ Time Span: _____

___ COVID-19 Vaccine Date of completed vaccine: _____

**Any additional information:**

_____

_____

_____

_____

_____

_____

# Medication Reconciliation – JMHCC Adult Day Care

**Resident Name:** _____ **Nurse Signature/Date:** _____

**Allergies:** _____

List below all of the resident's medications prior to admission including all prescriptions, herbals, over the counters, eye drops, inhalers, vitamins, and supplements.

| Home Medication | Dose | Route | Frequency | Last DoseDate/Time |
|---|---|---|---|---|
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