



## Vision

To be the preeminent provider shaping the future of Adult Day Health Services.

## Mission

Riverview Adult Day Health Center is a safe place providing accredited and licensed services for adults and offering compassionate care on a social, physical, emotional and spiritual basis.

## Core Values

**Compassionate Care** - Committed to caring for guests with love, dignity, and respect.

**Professional Health Care** - Providing licensed and certified staff to monitor health status, administer medications, consult with physicians and assist in physical needs as appropriate.

**Personal Well-Being** - Encouraging activity, mental stimulation, and social engagement.

## Objectives

**Teamwork** - Working together with families, staff, and guests to bring positive solutions to difficult circumstances

**Inclusiveness** - Open to all without discrimination

**Collaboration** - Providing a community resource that coordinates with state, federal and local agencies

**Affordability** - Seeking to be a not-for-profit organization that maintains affordable fees through grants, state and federal programs, fundraising, and volunteerism

**Individualization** - Planning to provide appropriate physical, medical and social activity personalized for each guest

**2715 East Jackson Blvd • Elkhart, Indiana 46516 • 574-293-6886 • Fax 574-295-9290**



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## **WHAT TO BRING ON THE FIRST DAY**

On the first day of attendance, please be sure to bring the following items:

- ❑ All enrollment forms, along with a copy of Advanced Directives (if applicable) and a copy of Power of Attorney (if applicable).
- ❑ We ask that all participants have a change of clothing in case of a spill or accident. This includes a change in top and bottom garments as well as undergarments. If guest wears protective underwear (Depends), include these as well. Be sure to label clothing with guest's name. Also, label any outer garments, such as sweaters or jackets.
- ❑ Allow for extra time on the first day in order to ensure that all documents have properly been completed and to ask or answer any last minute questions.

## **GENERAL GUIDELINES**

- ❑ We are open Monday – Friday, from 7:30 A.M. until 5:00 P.M.
- ❑ We encourage guests to attend at least two days a week to establish routine.
- ❑ If the guest is unable to attend on their regularly scheduled days or will be changing their schedule, please call by 8:00 A.M. for lunch scheduling.
- ❑ All medications that the guest is currently taking must be listed on the Physician's Order Form. Medications routinely being administered by Riverview ADC must be in a properly labeled prescription container.
- ❑ Caregivers are responsible for notifying the nurse of any changes in the guest's medication regimen or health status (including surgeries, etc.).



## **PARTICIPANT'S BILL OF RIGHTS**

Riverview Adult Day Center shall:

- Provide an individual with humane care and protection from harm.
- Provide services that are meaningful and appropriate and comply with standards of professional practice in a safe and supportive environment.
- Obtain written consent from an individual, or the individual's legal representative, if applicable, before releasing information from the individual's records unless the person requesting release of the records is authorized by law to receive records without consent.
- Process and make decisions regarding complaints filed by an individual within two (2) weeks after the provider receives the complaint.
- Inform an individual, in writing and in the individual's usual form of communication of their constitutional and statutory rights, and the grievance procedure established for processing complaints.

Guest or legal representative will be provided with copy of the Bill of Rights. Staff will answer any questions guest/guardian may have regarding their rights, and obtain signature for consent for treatment, authorization to pay benefits, release of photo or video, and release of medical information.

Grievances should be brought to attention of Director. A form will be given to guest/guardian to be completed and returned to Director. Director will review complaint and will make a decision on complaint no later than two (2) weeks from date of complaint. If a satisfactory resolution from the Director is not received, the complaint shall be forwarded to the President of the governing Board of Directors for review. If a satisfactory resolution is still not received, the complaint shall be forwarded to any of the following:

The Joint Commission  
(630)-792-5795

State of Indiana Agency on Aging Area 2 Ombudsman  
Emily Hartzler  
(800)-552-7928

Participant's Bill of Rights shall be posted in common area.



# SUMMARY NOTICE OF PATIENT PRIVACY

**Effective:** April 14, 2003

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

***PLEASE REVIEW IT CAREFULLY.***

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. See the full Notice of Privacy Practices for details. Except as described in the full Notice of Privacy Practices, other uses of your medical information will only be done with your authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The date at the top right hand side of this page indicates the date this Notice became effective.

You have the right to receive a copy of your most recent Notice of Privacy Practices in effect. If you believe you have not yet received a copy of our most current Notice of Privacy Practices, please ask at the office and we will provide you with a copy, or call us at (574)293-6886.

If you have any questions, concerns or complaints about the Notice of your medical information, please contact the Riverview Adult Day Center Privacy Officer at 2715 E. Jackson Blvd., Elkhart, IN 46516



## **Frequently Asked Questions**

### ***What is Riverview Adult Day Center?***

Riverview ADC is an adult day center, which provides structured socialization and health monitoring for our guests, as well as respite for caregivers for over 26 years. We serve adults in the Elkhart County area and beyond who cannot be safely left alone, who demonstrate a decline in cognitive functioning, or who are just in need of increased socialization. Our hours of operation are Monday - Friday, 7:30am – 5:00pm.

### ***What types of activities are guests involved in?***

We have time set aside for social hour, current events, group and individual activities (crafts, baking, games, etc.), health updates, and more. Our day also includes exercise and games and a nutritious breakfast, lunch and snack. Plus monthly visits from the Potawatomi Zoo, Elkhart Public Library and entertainers. We also offer a secured wing for guests that wander.

### ***How many days a week of attendance are required?***

Attendance is flexible and determined according to the needs of guests and family. Scheduled attendance should consist of at least two half days (5 hours) per a week. This not only develops a schedule for your loved one, but it will enable the guest to establish a relationship with the staff and other guests

### ***What does the enrollment process involve?***

To enroll in our program, an enrollment interview needs to be scheduled in order for the Executive Director and Nurse to meet with the prospective guest. This meeting takes approximately 45 minutes. This meeting involves an overview of the program, including our mission, admission & discharge criteria, physician forms, and daily activities. We also conduct a quick assessment to ensure that our services are appropriate for the prospective guest.

Before a guest begins services with us, we need to have a Physician's Order form, completed by the primary care physician, testing for Tuberculosis (results included), and the enrollment paperwork. Information and forms will be provided during the enrollment interview.

### ***What are your daily Rates & Billing?***

(Pricing includes breakfast, hot lunch and a snack)

A flat fee of \$60.00 is charged for up to and including five (5) hours of attendance.

Additional hours will be at \$12.24 per hour, in 15-minute increments of \$3.06

Up to 5 hours in one day ..... \$60.00

Each additional 15-minute increment .... \$3.06

(Example: 5 ½ hours = \$60.00 + 6.12 = \$66.12)

Caregivers are billed twice monthly following the service rendered. Payment is due upon receipt of the invoice.

***What do you charge for transportation?***

Daily transportation fee of \$5.00 plus a mileage fee of .545 per a mile (round trip)

The daily transportation fee will be waived if the guest attends Riverview ADC full time. The guest/caregiver will still be responsible for the daily mileage fee.

***Are there financial aid programs available?***

For information regarding financial assistance, please notify the Executive Director. The Center has a contract with the Veterans Administration, accepts Medicaid Waivers and Choice Program.

***Do you provide any health care?***

We prepare a Care Plan on all our guests which may include monitoring vital signs and health conditions and administering medications. The nurse is also able to act as a liaison between the guest/caregiver and the physician or other health professionals if needed. We provide assistance with activities of daily living as described in Riverview's admission criteria.

***Who am I leaving my loved one with?***

Our staff consists of the following qualified personnel: Executive Director, Health Services Director (LPN), Program Director, Qualified Medication Aide and Certified Nurses Assistant.

***What is your affiliation with Trinity United Methodist Church?***

Riverview Adult Day Center is a Not-For-Profit organization. Although we are located inside Trinity UMC and we are a mission of the church, Riverview is a separate entity. We maintain affordable fees for optimal services through grants, donations, fund raising and volunteerism.

***How can I help?***

- Volunteer! Our volunteers are the backbone of our program. We rely on them to provide additional support during programming and activities so staff can focus on guest care. In addition to volunteering, we also have a wish list of items that we use everyday. You can find wish list items on our monthly newsletter or ask staff for a list. In kind and financial donations are always welcome and needed.
- Name Riverview ADC as your Memorial choice.
- Join the Board of Directors
- [info@riverviewaduldaycenter.org](mailto:info@riverviewaduldaycenter.org)

# Enrollment Form



<b>Guest Name:</b>	
Age & Gender:	
Date of birth:	
Phone #:	
Address:	
Address cont.	
Insurance Info:	
Medicaid/Medicare#:	
SS#:	
Living Arrangements:	
Referred By:	

<b>POA Name:</b>	
Home phone:	
Work phone:	
Cell phone:	
Address:	
Address cont.:	
Email Address:	

<b>EMERGENCY CONTACT #2</b>	
Name:	
Phone:	
Alt Phone:	

<b>EMERGENCY CONTACT #3</b>	
Name:	
Phone:	

<b>Medical Info:</b>	
Physician:	
Physician's phone #:	
Hospital:	
Diabetic:	

<b>DNR:</b>	<b>YES OR NO</b>
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## Personal History Form

Date:  
Guest Name:  
Person filling out form:  
Relationship with guest:


Education:  
Occupation:  
Military Service:  
Interests:  
Hobbies:


Childhood History:


Family History:


Other Significant family members or friends:


Any bereavement issues?


Any support groups or systems guest or family have used in the past or are currently using?


Any special needs or preferences for care, treatment or services?


What are the goals for the guests for the future and what are they/you hoping to achieve by attending Riverview ADC?


Other info:




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## **EMERGENCY RESUSCITATION PROCEDURES**

I, \_\_\_\_\_, or my legal representative, hereby acknowledges that Riverview Adult Day Center is not a Health Facility pursuant to Indiana Code Section 16-18-2-167 and therefore is not obligated to make a final decision of what may or may not constitute a cardiac or pulmonary failure under a Do Not Resuscitate (“DNR”) order.

I hereby acknowledge that Riverview Adult Day Center may respond, to the best of its ability, to any medical emergency I might have while under Riverview Adult Day Center supervision. I understand and agree that such a response may indicate the administration of cardio-pulmonary resuscitation even though I may have executed a DNR order. If I have executed the “State of Indiana Out of Hospital Do Not Resuscitate Declaration” form (see Indiana Code 16-36-5), it is my responsibility to provide Riverview Adult Day Center with a copy of the form. This form will be given to EMS on their arrival.

I hereby acknowledge that it is the policy of Riverview Adult Day Center, to call an emergency medical service (“EMS”) when a person under Riverview Adult Day Center supervision appears to be experiencing any medical emergency and I hereby release Riverview Adult Day Center from any liability that may result from the notification of an EMS.

\_\_\_\_\_  
Signature of Guest or Legal Rep.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



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**AUTHORIZATION FOR DISPENSING MEDICATIONS AT  
RIVERVIEW ADULT DAY CENTER**

Medications which have been prescribed by a physician will be given at Riverview Adult Day Center. Non-prescription medications, such as aspirin, Motrin, Tylenol, and antacids may be given (PRN) according to label directions if we have a signed authorization from the guest's physician, caregiver, or guardian.

Medications must be properly identified. The medication must be labels with the medication name and dosage or be in its original container.

Complete the lower portion of this form and return it to us with the medication. If more than one medication is to be given, it should be recorded on an additional form.

**NO MEDICATION WILL BE DISPENSED UNLESS THIS FORM IS PROPERLY FILLED OUT.**

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I authorize and request personnel at Riverview Adult Day Center responsible for

\_\_\_\_\_ to give the following Over-The-Counter Medication,  
Guest Name

\_\_\_\_\_ Medication name

\_\_\_\_\_ Dosage

\_\_\_\_\_ Time to be given/As Needed

\_\_\_\_\_ Signature of POA/guardian

\_\_\_\_\_ Date



### HIPAA GUEST CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking the Administrator for one.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name (printed): \_\_\_\_\_

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

Date: \_\_\_\_\_

Witness Name (printed): \_\_\_\_\_

Witness signature: \_\_\_\_\_

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### PARTICIPANT'S BILL OF RIGHTS RECEIPT

I have received a copy of the Participant's Bill of Rights and am aware of its contents.

Name (printed): \_\_\_\_\_

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

Date: \_\_\_\_\_

Witness Name (printed): \_\_\_\_\_

Witness signature: \_\_\_\_\_



### LIABILITY RELEASE FORM

The undersigned hereby releases Riverview Adult Day Center, Inc. and all of its officers, directors, employees, staff and volunteers, and Trinity on Jackson, its officers, directors, ministers, staff, employees, and volunteers of and from any and all claims for injury, losses, costs and expenses incurred by the undersigned or the Guest from any accident, injury, illness or loss of personal property suffered or incurred in connection with any services, programs or care provided or performed by Riverview ADC.

In case of emergency, I hereby give permission to Riverview ADC, its staff, employees and volunteers to summon or perform emergency services for the Guest and/or arrange transportation to the hospital that is most available. I understand that such emergency, hospital or physician services will be billed directly to me and that Riverview ADC will not be held responsible for payment of such services.

Name of Guest: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_

Date Signed: \_\_\_\_\_

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### PHOTO RELEASE FORM

I hereby grant Riverview Adult Day Center permission to use my likeness in photographs and/or video in any and all of its publications, including Web space, and in any and all other media, whether now known or hereafter existing, **controlled by Riverview Adult Day Center**, in perpetuity, and for other use by the Center. I will make no monetary or other claim against Riverview Adult Day Center for the use of the photographs and/or video.

I understand this release can be withdrawn at any time.

Name of Guest: \_\_\_\_\_

Name (print full name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### OFF PREMISES RELEASE

I hereby grant Riverview Adult Day Center permission to escort guest of Riverview ADC off premises for an outing, lunch, or medical appointment.

Name of Guest: \_\_\_\_\_

Name (print full name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## ADMISSION POLICY

**POLICY:** To provide for & facilitate fair and informed admission to Riverview Adult Day Center.

**PROCEDURE PURPOSE:** To ensure an orderly process and set forth the requirements for consistent and appropriate selection and admission of guests.

**Ambulation:**

- Must be able to ambulate independently or with assistance of wheelchair or walker.
- Must be able to transfer with one person.
- Must be able to bear own weight.

**Feeding:**

- Must eat independently or with minimal cueing.

**Toileting:**

- Must be able to maintain bowel control with minimal assistance.
- May have minimal urine incontinence.
- Must display adequate toileting hygiene to prevent odors.

**Communication:**

- Guest is able to follow simple directions.
- Guests who speak a foreign language, not English, require an interpreter at all times.
- Guests must be able to make their needs understood.

**Program Participation:**

- Guest will participate 50% of the time.
- Guests will benefit from the social environment as evidenced by interaction with others.

**Supervisory Requirements:**

- Guest will benefit from a group setting with a staff: group ratio of 1:4.

**Wandering:**

- Guest should be redirectable in his/her wandering.
- Guest should be willing to remain in secure area.

***The guest or family caregiver will sign this admission/non-admission/discharge form honestly and to the best of their ability.***

**I HAVE READ AND HAVE ANSWERED QUESTIONS AND ACKNOWLEDGED KNOWN BEHAVIOR OF THE GUEST REQUESTING ADMISSION HONESTLY AND TO THE BEST OF MY ABILITY.**

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



## DISCHARGE POLICY

**POLICY:** To provide for & facilitate fair and informed discharge from the Riverview ADC program.

**PROCEDURE PURPOSE:** To ensure an orderly process and to set forth the requirements for consistent and appropriate selection and dismissal of guests.

Those who are not eligible for admission include those persons who require more assistance than the Center staff can provide, are beyond the scope of services, those who have a contagious disease, and those who are a danger to themselves or others.

Due to the congregate nature of the program, Riverview ADC reserves the right to refuse services. All Riverview ADC guests will be monitored on a weekly basis to determine whether or not they meet any of the criteria for discharge.

*THIS WOULD INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING:*

**Ambulation:**

- Guests who cannot pivot for transfers, need lifting and those who cannot bear weight.

**Feeding:**

- Those who need assistance which may require continual queuing.
- Those who display eating habits which are unacceptable in a group setting.

**Toileting:**

- Persons with frequent urinary/bowel incontinence requiring more than minimal assistance by staff.
- Consistent body odor due to poor hygiene with unwillingness to improve.

**Program Participation:**

- If guest sleeps excessively or isolates, not participating in program activities 50% of the time.

**Supervisory Requirements:**

- 1:1 staff needed to be with guest more than one third of the time.
- If medical condition or diagnosis requires 1:1 nursing supervision beyond our scope of care.

**Wandering:**

- Guest is non-redirectable in his/her wandering.
- Guest repeatedly refuses to remain within secure area.

**Disruptive and Unacceptable Behavior:**

- Combative behavior such as hitting, kicking, grabbing, spitting etc., are grounds for immediate discharge. A deteriorating physical/mental condition resulting in guest being a danger to himself or others. Threatening others physically or verbally.
- Inappropriate language such as swearing, cursing, insulting or berating others.
- Sexual comments and gestures. Inappropriate sexual conduct.
- Frequency and intensity or duration of guest's behavior continues after being explained the expectations & after staff interventions the situation remains uncontrollable and non-redirectable. Disruptive behavior that affects the health, happiness and well being of the other guests and/or the effective operation of the program.

**2 Week Trial:** A guest that is on a 2-week trial basis and is deemed to be inappropriate for adult day services.

*If one or several of the discharge criteria have been met by a guest, the Director/nurse will notify (in writing) the guest and his/her family of the need to change arrangements. Thirty (30) day notice will be provided, however the Riverview Staff reserves the right to immediately suspend, without proper notice.*

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