Attachment O
National Facility Questionnaire

Introduction

This survey is about the characteristics of residential care facilities and the individuals who live in them.

Residential care facilities are known by many names, so just to be clear, I would like to read a definition that we are using to describe a residential care facility.

SHOWCARD 1. "Residential care facilities are places that are licensed, registered, listed, certified, or otherwise regulated by the state and that provide room and board with at least two meals a day, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health related services such as medication management. These facilities serve an adult population. Facilities licensed to serve the mentally ill or the MR/DD populations exclusively are excluded."

When you answer the questions please answer only about the residential care ***component*** of this facility.

Number of beds /Residents

Some states license, register, or certify residential care facilities by number of beds, while other states regulate by the number of units. The next questions are about both the number of beds and the number of units in this facility. A unit is defined as a room or apartment where residents live. Do not include rooms within apartments.

A1. At this facility, what is the number of licensed, registered, or certified residential care beds

_____

A2. [CAPI: ASK ONLY IF STATE LISCENSES BY UNITS]
At this facility, what is the number of licensed, registered, or certified residential care units

_____

A3. What is the current number of residents living at this residential care facility? ____

A4. The next few questions are about apartments. An apartment is a living unit that includes lockable doors, a bathroom with a sink, toilet, and shower or bath, and a kitchen area which includes a sink, at least a cook top, hotplate, or microwave and a refrigerator.

Based on this definition, do any of your units qualify as an apartment?
O YES
O NO – {CAPI SKIP A5a, A5b, A5c, and A6a, A6b, A6c}

A5. How many of these units are….	**Number of Apartments/ Rooms**
a. Studio apartments	_____
b. One bedroom apartments	_____
c. Two bedroom apartments	_____
d. Room designed for one person	_____
e. Double occupancy rooms	_____
f. Rooms for three or more residents	_____

A6. How many apartments include a kitchen area that contains…
A6a. A cook top or hot plate [ ]
A6b. A microwave [ ]
A6c. An oven [ ]

(CAPI: IF A4=YES GOTO A8)

A7. How many units have a door to the hallway that can be locked? [ ]

A7_within. How many rooms have a bathroom located within the room? _____

A7_bath. {If A7_within = 0 GO TO A8}

How many rooms…
A7a. have a <u>full bathroom</u> including a toilet, sink, and shower or tub located within the room [ ]
A7b. have a <u>half-bath</u> including a sink and toilet located within the room [ ]

QUESTIONS A1-A7b WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

A8. Does the facility have a common kitchen area that any resident can use?
O YES
O NO

A9. How many of the residents live with a spouse or other relative?
R SHOULD COUNT THE TOTAL NUMBER OF RESIDENTS. [ ]

Facility Characteristics

A10. {CAPI – IF SMALL FACILITY: What is the total number of years this facility has been in operation? Else}: What is the total number of years this facility has been in operation providing residential care?

O LESS THAN 5 YEARS (READ RESONSES IF NECESSARY)
O 5 TO 9 YEARS
O 10 TO 19 YEARS
O 20 OR MORE YEARS

A11. Was {fill name of facility} purposely built as a residential care facility?"
O YES
O NO

A12. Does the residential care component of this facility have:	**NONE**	**SOME**	**ALL**
a. Smoke detectors in resident rooms and apartments	**O**	**O**	**O**
b. Smoke detectors in common areas	**O**	**O**	**O**
c. A sprinkler system in resident rooms and apartments	**O**	**O**	**O**
d. A sprinkler system in common areas	**O**	**O**	**O**
e. Supported or grab rails in hallways	**O**	**O**	**O**
f. Widened hallways or doorways to accommodate wheelchairs	**O**	**O**	**O**
g. An emergency call or personal response system in the rooms or apartments	**O**	**O**	**O**
h. Wheelchair accessible rooms or apartments	**O**	**O**	**O**
i. Bathrooms with enough space for a wheelchair to enter (about 3 ft) and turn around (about 5ft x 5ft)	**O**	**O**	**O**
j. Bathrooms with grab bars in the shower or tub area	**O**	**O**	**O**

A13. {CAPI: GO TO A14 IF SMALL FACILITY}
Is there a centrally-located nurses' station on each floor?
O YES
O NO

A14. Does this residential care facility have a…	YES	NO
a. wellness or lifestyle program which provides services such as blood pressure screenings, nutrition counseling, and diet and exercise programs.	**O**	**O**
b. a place where doctors or other medical providers can see their patients	**O**	**O**

A15. During the past 90 days, had this residential care facility routinely provided short-term respite care?

O YES
O NO

A16. Does this facility provide adult day health/ adult day care services to non-residents?

O YES
O NO

A17. Does this facility serve any people with developmental disabilities, such as mental retardation, autism, or Down syndrome?

O YES
O NO

A18. Does this facility serve any people who have severe mental illness, such as schizophrenia and psychosis? Please do not include Alzheimer's disease or other dementias.

O YES
O NO

A18a **SHOWCARD 2.** We would now like to ask you about how the facility manages risky behavior by residents. By risky behavior, we mean when residents do things that staff think pose a risk to their health and safety - such as refusing to take prescribed medications, not using a walker when their balance is poor, or not complying with prescribed diets.

Some facilities use a formal document called a managed risk agreement or a formal negotiated risk agreement, which documents the risky behavior, discussions with the resident about the behavior, alternatives to the behavior presented by staff, and agreements reached between the facility and the resident about the behavior. Some facilities also use these documents as liability waivers for harm resulting from risky behavior.

Does this facility develop a formal negotiated risk agreement with some or all residents?

O YES - {CAPI: GOTO A19}
O NO

A18b. Instead of a formal negotiated risk agreement, does this facility address risky behaviors in the service plan?

O YES
O NO

A18c. Instead of a formal negotiated risk agreement, does this facility talk to the residents or their relatives about the risky behaviors?

O YES
O NO

Home-Like Environment

The next questions ask about items residents are allowed to bring when they move into this facility.

A19. What types of personal items or furniture may residents bring? Please select all that apply.

☐ Large furniture such as a couch, bed, or dining room table.

☐ Small furniture such as a desk, bookcase, chair, lamp, or small table.

☐ Personal items such as pictures, bed linens, or wall decorations.

A20. Does the facility provide a common pet?

O YES
O NO

A20a. Are residents ever allowed to have a personal pet such as a cat, dog, or bird?

O YES
O NO

A21. Is there space at this facility for residents to park their car(s)?

O YES
O NO

Source of Payment

The next questions ask about resident source of payment.

A22. Is this residential care facility certified or registered to participate in Medicaid?

O YES
O NO

A23. During the last 30 days, how many of the residents had some or all of their long-term care services at this facility paid by Medicaid?_____

QUESTION A23 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

Waiting Lists

A24. Does this facility have an active waiting list {CAPI: IF MULTI-LEVEL: for residential care}?
O YES
O NO – SKIP TO A27

A25. What is the current number of people on the active waiting list for residential care?
_____

A26. What is the average length of time that prospective residents are on the waiting list for residential care before admission? Please respond in months and/or days.

_____DAYS
_____MONTHS

QUESTIONS A25-A26 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

Resident Turnover: Admissions/Discharges

The next questions ask about resident admission and discharge.

A27. How many residents moved into this facility over the past 12 months?
Note: Please count couples separately. Do not include as an admission, returning from a "temporary discharge" to a hospital if this facility held the bed for the resident.
_____ADMISSIONS IN PAST 12 MONTHS

A30. Over the last 12 months, how many residents moved out of this facility? Do not include deaths. _____ {CAPI: IF A30=0 GO TO A32}

AXX. Over the last 12 months, of those residents who moved elsewhere, how many left because the cost of care (including housing, meals, and services required to meet their needs) exceeded their ability to pay? _____

A31. Where did the residents go after they moved out? Please provide the total number in each category?
_____Hospital
_____Nursing home
_____Another residential care facility
_____Private residence
_____Other

QUESTIONS A27, A30, A31 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

A32. In the last 12 months, how many residents died? _____

Staffing (e.g., RNs, LPNs)

The next questions are about facility staff.

A33. During the last 7 days, how many total hours were worked by <u>paid</u> employees {CAPI IF MULTI_LEVEL: for the <u>residential care</u> portion of this facility}? **- Please only include employees that provide direct care to residents.** **- Please include full-time and part-time staff** **- Please count hours for each staff person only ONCE based on their primary responsibilities**	**HOURS WORKED**
a. Registered Nurses (R.N.)	_____
b. Licensed Practical Nurses (L.P.N.) or Licensed Vocational Nurses (L.V.N.)	_____
c. Personal care aides /nursing assistants	_____
d. Activities director/ activities staff	_____
e. Administrator/assistant administrator - direct care time only	_____

QUESTION A33 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

A34. Does this facility routinely use contract or agency workers to provide direct care to residents?
O YES
O NO

A35. During the past 7 days, how many volunteers visited this facility? _____

A36. During the last 7 days, what is the total number of volunteer hours? _____

A37. Thinking about the last 7 days, how many staff were on-duty and awake at night during a typical night? Please do not count security guard(s). _____

A38. As of today, how many of the following **full time and part time** staff are currently employed at this facility {CAPI: IF MULTILEVEL ADD: for residential care}? Please count each staff person only ONCE based on their primary responsibilities	**Current Staff**
a. Administrators/Director	_____
b. Registered Nurses (R.N.)	_____
c. Licensed Practical Nurses (L.P.N.) / Licensed Vocational Nurses (L.V.N.)	_____
d. Personal Care Aide	_____

A39. During the past 12 months, how many of the following **full time and part time** staff have resigned or been terminated {CAPI: IF MULTILEVEL ADD: for residential care}?	**Resigned/ Terminated**
a. Administrators/Director	_____
b. Registered Nurses (R.N.)	_____
c. Licensed Practical Nurses (L.P.N.) / Licensed Vocational Nurses (L.V.N.)	_____
d. Personal Care Aide	_____

QUESTION A38-A39 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

Staff Training

A40. Does this facility provide on-going, in-service training to personal care aides?
O YES
O NO

A41. Prior to providing care to residents, how many hours of formal training are required of direct care staff?
O No formal training
O Less than 75 hours of training
O 75 hours of training
O More than 75 hours of training

A42. Do you only hire personal care aides that are already trained as Certified Nursing Assistants or Home Health Aides?

O YES
O NO

A43. In addition to helping with activities of daily living, such as dressing, do personal care aides routinely perform any of the following tasks… SELECT ALL THAT APPLY

☐ Housekeeping such as making beds, dusting, and sweeping

☐ Janitorial services

☐ Assistance with food preparation

☐ Assistance with recreational activities

☐ Resident's personal laundry

☐ Other (specify): _____

A44. Does this facility offer the following benefits to direct care employees?	**YES**	**NO**
a. health insurance for the employee only	O	O
b. health insurance, including family coverage	O	O
c. life insurance	O	O
d. long-term care insurance	O	O
e. pension/401(k)/403(b)	O	O
f. personal time off/vacation time/sick leave	O	O
g. tuition reimbursement	O	O
h. child care	O	O

A45. IF YES TO A44a or A44b: Does this facility pay for more than half of the employee's health insurance premium?

O YES
O NO

Record Keeping (types of information maintained)

The next questions ask about the types of information maintained by this facility.

A46. Does this facility conduct a formal functional assessment of residents using a standardized tool before or upon admission?

Note: Functional means physical (e.g., activities of daily living, such as eating, bathing, and dressing) or cognitive functioning

O YES
O NO -- GO TO A48

A47. Does this assessment include a physical assessment, cognitive assessment, or both?

O PHYSICAL ASSESSMENT
O COGNITIVE ASSESSMENT
O BOTH PHYSICAL AND COGNITIVE ASSESSMENT

A48. Does this facility develop formal individual service plans?

O YES
O NO

A49. Other than for accounting purposes, does this facility have a computerized system for resident service records? For example, an Electronic Medical Records System.

O YES
O NO – SKIP TO A52a

A50. **SHOWCARD 3.** In that computerized system, which of the following components are included? You may select all that apply

☐ Resident demographics
☐ Functional assessments
☐ Individual service plans
☐ Clinical notes, such as daily progress notes
☐ Medication administration (for example, for maintaining lists of resident's medications)
☐ Discharge and transfer summaries
☐ Electronic Point of Care Documentation (for example, handheld devises for charting or for other clinical notations)

A51. **SHOWCARD 4.** Does this system support electronic health information exchange with any of the following entities? For example, sending electronic records from this facility to a hospital. You may select all that apply.

☐ Physicians
☐ Nursing homes
☐ Hospitals
☐ Pharmacies
☐ Other health or long-term care providers
☐ Resident's personal health record
☐ Corporate office
☐ Electronic information is NOT exchanged.

Demographics of residents

The next questions involve resident demographics.

A52_male. What is the total number of male residents living at this facility? _____

A52_female. What is the total number of female residents living at this facility? _____

{CAPI: TOTAL NUMBER OF A52_male and A52_female SHOULD EQUAL A3. ELSE: The number of males and females living at this facility does not match the {fill A3) total number of resident you provided earlier in this survey}

A52. What percentage of residents are in the following age categories?

a.	17 and under	_____%
b.	18-54	_____%
c.	55-64	_____%
d.	65-74	_____%
e.	75-84	_____%
f.	Age 85 and over	_____%

A53. How many residents are of Hispanic, Latino, or Spanish origin or descent? _____

A54. What percentage of residents are…

_____ %	White/Caucasian
_____ %	Black or African American
_____ %	Asian
_____ %	Native Hawaiian or other Pacific Islander
_____ %	American Indian or Alaskan Native
_____ %	Other

QUESTIONS A52_male-A54 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT

Administrator Estimates of Cognitive, Functional and Health Status of Residents

The next questions ask about the cognitive, functional, and health status of residents.

A55. During the last 7 days, how many of this facility's residents had short-term memory problems or seemed disoriented all or most of the time?

NOTE: This includes, for example, residents who are not able to remember things after a short while, residents who have difficulty remembering where their room is, or difficulty recognizing staff names or faces, and residents who have difficulty organizing their daily routine.

_____

SHOWCARD 5. **A56. What percent of the residents…**	**75 - 100%**	**50 - 74%**	**25 - 49%**	**0 - 24%**
a. have had an episode of urinary incontinence during the last 7 days?	O	O	O	O
b. are confined to a bed or chair because of health problems?	O	O	O	O
c. use a wheelchair to get around in the facility?	O	O	O	O
d. currently receive assistance in transferring in and out of bed or a chair?	O	O	O	O
e. currently receive assistance in eating? (e.g. cutting up food)	O	O	O	O
SHOWCARD 5. **A57. For what percentage of the residents do you…**	**75 - 100%**	**50 - 74%**	**25 - 49%**	**0 - 24%**
a. manage, supervise or store medications or provide assistance with self-administration of medications?	O	O	O	O
b. provide or arrange assistance with locomotion, that is, helping the resident walk or wheel him/herself around the facility?	O	O	O	O
c. provide or arrange assistance using the bathroom. This includes reminders to use the toilet, scheduled toileting, getting on or off the toilet, cleaning him/herself, arranging clothing, and changing adult incontinence supplies?	O	O	O	O

Dementia/Alzheimer's Unit

CAPI: IF SCREENING QUESTIONNIARE (S3c=YES) GOTO A61

A58. Does this residential care facility have a distinct unit/wing/floor that is designated as a Dementia/Alzheimer's Special Care Unit?

O YES
O NO – SKIP TO B1

The next set of questions is about the Dementia or Alzheimer's unit / floor / wing. When answering these questions, please answer only for that unit.

A59. In the Dementia/Alzheimer's Special Care unit, please tell me the number of licensed beds _____

A60. What is the current number of residents living in the Dementia/ Alzheimer's unit? _____

QUESTIONS A59-A60 WILL BE PROVIDED TO RESPONDENT PRIOR TO SITE VISIT. WE RECOMMEND ASKING THE RESPONDENT TO HAVE THIS INFORMATION COLLECTED ON DATE OF VISIT.

A61. **SHOWCARD 6.** Which of the following features does {CAPI: IF SCREENER S3c=YES THEN FILL: "this facility have?" else "this Dementia/ Alzheimer's Special Care Unit have?"}

SELECT ALL THAT APPLY

☐ Locked exit doors
☐ Doors with alarms
☐ Doors with keypads
☐ Personal monitoring devices
☐ An enclosed courtyard
☐ Higher staff-to-resident ratios compared to other units
☐ Specially trained staff
☐ Dementia-specific activities and programming
☐ Other: SPECIFY:_____

B. Facility Policies / Services

The next questions will be about policies and services provided {CAPI: FILL WITH "at {NAME OF FACILITY}", ELSE IF MULTILEVEL FACILITY: "by the residential care portion of this facility."}

Admission Policy (who admitted/excluded)

B1. In terms of this facility's admission policy, do you admit a resident who…	**YES**	**NO**	**DECISION MADE ON A CASE-BY-CASE BASIS**
a. Is unable to leave the facility in an emergency without help	**O**	**O**	**O**
b. Has moderate to severe cognitive impairment (e.g. resident does not know who they are)	**O**	**O**	**O**
c. Exhibits problem behavior such as wandering, temper outbursts, or combative behavior to other residents	**O**	**O**	**O**
d. Needs skilled nursing care on a regular basis	**O**	**O**	**O**
e. Needs daily monitoring for health condition (e.g., assistance taking insulin or monitoring blood sugar)	**O**	**O**	**O**
f. Is regularly incontinent of urine	**O**	**O**	**O**
g. Is regularly incontinent of feces	**O**	**O**	**O**
h. {CAPI: IF EITHER B1f OR B1g = "NO" GO TO B1i else:} Is regularly incontinent of both urine and feces	**O**	**O**	**O**
i. Needs two people to help them get in and out of bed or needs a Hoyer lift to get in and out of bed	**O**	**O**	**O**
j. has a history of drug or alcohol abuse	**O**	**O**	**O**

B2. Are there any other reasons for which you would refuse to admit someone?
O YES - SPECIFY: [ALLOW 80]
O NO

Discharge Policy (reasons for discharge)

B3. In terms of this facility's discharge policy, do you discharge a resident who…	**YES**	**NO**	**DECISION MADE ON A CASE-BY-CASE BASIS**
a. {CAPI: IF B1a=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Is unable to leave the facility in an emergency without help	**O**	**O**	**O**
b. {CAPI: IF B1b=NO DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Has moderate to severe cognitive impairment (e.g. resident does not know who they are)	**O**	**O**	**O**
c. {CAPI: IF B1c=NO OR DECISION MADE ON A CASE-BY-	**O**	**O**	**O**

CASE BASIS} ASK: Exhibits problem behavior such as wandering, temper outbursts, or combative behavior to other residents			
d. {CAPI: IF B1d=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Needs skilled nursing care on a regular basis	**O**	**O**	**O**
e. {CAPI: IF B1e=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Needs daily monitoring for health condition (e.g., assistance taking insulin or monitoring blood sugar)	**O**	**O**	**O**
f. {CAPI: IF B1f=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Is regularly incontinent of urine	**O**	**O**	**O**
g. {CAPI: IF B1g=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Is regularly incontinent of feces	**O**	**O**	**O**
h. {CAPI: IF EITHER B1f OR B1g = "NO" GO TO B3i else:} {CAPI: IF B1h=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Is regularly incontinent of urine & feces	**O**	**O**	**O**
i. {CAPI: IF B1i=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: Needs two people to help them get in and out of bed or needs a Hoyer lift to get in and out of bed	**O**	**O**	**O**
j. {CAPI: IF B1j=NO OR DECISION MADE ON A CASE-BY-CASE BASIS} ASK: has a history of drug or alcohol abuse	**O**	**O**	**O**

B4. Are there any other reasons for which you would discharge someone?
O YES - SPECIFY: [ALLOW 80]
O NO

Types of Services Provided on Site

B5. Does this facility provide any of the following services to residents…	**YES**	**NO**	**IF YES: Is this service provided by facility staff or arranged by the facility and provided by non-facility staff?**
a. Special diets	O	O	a1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
b. Assistance with activities of daily living	O	O	b1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
c. Assistance with a bath or shower at least once a week	O	O	c1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
d. Skilled nursing services	O	O	d1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
e. Basic health monitoring (e.g., blood pressure and weight checks)	O	O	e1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO

f. Social and recreational activities within the facility	O	O	f1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
g. Social and recreational activities outside the facility	O	O	g1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
h. Incontinence care	O	O	h1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
i. Transportation to medical or dental appointments	O	O	i1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
j. Transportation to stores and elsewhere	O	O	j1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
k. Personal laundry	O	O	k1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
l. Linen laundry services	O	O	l1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
m. Social services counseling	O	O	m1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
n. Case management	O	O	n1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
o. Occupational therapy	O	O	o1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
p. Physical therapy	O	O	p1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
q. Transportation to a sheltered workshop, work training program or supported employment	O	O	q1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO
r. Transportation to an education program	O	O	r1. 1. PROVIDED BY FACILITY STAFF OYES ONO 2. PROVIDED BY NON-FACILITY STAFF OYES ONO

B5_other. Does this facility offer…

		YES	NO
B5_cable.	cable TV access in resident rooms or apartments?	**O**	**O**
B5_tele.	landline telephone access in resident rooms or apartments?	**O**	**O**
B5_int.	Internet access in resident rooms or apartments?	**O**	**O**

B5_assist. **SHOWCARD 7.** Do any of the residents use any of the following… SELECT ALL THAT APPLY.

☐ Amplifier for the telephone
☐ TDD, TTY or teletype
☐ Assistive listening devices
☐ Signaling devices (devices which can visually alert the hearing impaired person to auditory signals that may not be heard)
☐ Communication board
☐ Other equipment for people with hearing or speech impairments?

B5b. Do residents have public internet access available in the facility?
O YES
O NO

Medication Administration

B6 Do all residents take their medications on their own?
O YES
O NO – GO TO B9

B7a. **SHOWCARD 8.** Do you or other staff assist residents with medications in any of the following ways… SELECT ALL THAT APPLY.

☐ Central location where medications are stored prior to administration to residents
☐ Providing medication reminders (e.g. prompting that it is time to take medications)
☐ Delivering pre-packaged unit doses
☐ Helping with administration, for example, open the bottle and hand the resident the correct dose.
☐ Helping the resident take the medicine (e.g., putting it in their mouth and handing the resident a glass of water)
☐ Providing oversight and cueing to make sure the resident actually takes the medication
☐ Administering drops, topical ointments, etc.
☐ Administering IV medications
☐ Administering injections

B7b. **SHOWCARD 9.** Who passes or hands the residents their prescription medications? Passing medications includes the delivery of pre-packaged doses or opening the bottle and handing the resident the correct dose. SELECT ALL THAT APPLY.

☐ RN
☐ LPN
☐ Certified medication aide / supervisor / medication technician

☐ Personal care aide

☐ Owner /Administrator / assistant director / manager

B8. **SHOWCARD 9.** Who administers prescription medications to the residents? Administering medications includes placing the medication in residents' mouths and handing them glasses of water, giving injections, giving IV medications, or applying prescription topical ointments and creams. SELECT ALL THAT APPLY.

☐ RN

☐ LPN

☐ Certified medication aide / supervisor / medication technician

☐ Personal care aide

☐ Owner /Administrator / assistant director / manager

(CAPI: IF B8 = Personal care aide, owner/ administrator / assistant director / manager} THEN CONTINUE, ELSE B9

B8_lic. {CAPI: IF PERSONAL CARE AIDE, OWNER/ADMINISTRATOR/ASSISTANT DIRECTOR /MANAGER ONLY SELECTED THEN "Is this person a licensed nurse or certified medication aide?"} {CAPI: IF MULTIPLE SELECTIONS OF RN PERSONAL CARE AIDE, OWNER/ADMINISTRATOR/ASSISTANT DIRECTOR /MANAGER THEN "Are these individuals licensed nurses or certified medication aides?"

O YES
O NO
O SOME

B9. Does the facility have a pharmacist or doctor review the medications that residents receive for appropriateness?

O YES
O NO

Use of restrictive devices

B10. Does this residential care facility ever use physical restraints such as lap buddies, posey restraint, bed rails, or Gerry chairs?

O YES
O NO

B11. Do facility staff regularly give drugs to residents to control behavior or to reduce agitation? This includes drugs prescribed by a physician or other medical provider.

O Yes
O No

Charges and Reimbursement rates (amount and what it covers)

The next series of questions are about charges to the resident.

B12a. How is the base rate structured? Does this facility offer a flat base rate or is there a rate that varies by disability? Do not include variations in charges by room type or size.

O Flat base rate
O Rate varies by disability

B12b. Can the residents obtain additional services, beyond the base rate, on a fee-for-service basis?

O YES
O NO

Average Rates and Pricing

	YES	***NO***
B13. Is a security deposit required	**O**	**O**
B14. Does this facility charge an entrance fee prior to moving in?	**O**	**O**

B15. What is the <u>average monthly base rate</u> for both the room/apartment rent and the services? Please provide the rate for a single individual living in this unit.	Per Resident/ Regular Unit ENTER AVERAGE AMOUNT	Per Resident/ Alzheimer's Unit (if applicable) ENTER AVERAGE AMOUNT
a. CAPI FILL "Studio Apartments" if A2a > 0	**$_____**	**$_____**
b. CAPI FILL "One bedroom apartments" if A2b > 0	**$_____**	**$_____**
c. CAPI FILL "Two bedroom apartments" if A2c > 0	**$_____**	**$_____**
d. CAPI FILL "Room designed for one person" if A2d > 0	**$_____**	**$_____**
e. CAPI FILL "Double occupancy rooms" if A2e > 0	**$_____**	**$_____**
f. CAPI FILL "Rooms for three or more residents" if A2f > 0	**$_____**	**$_____**
g. CAPI FILL "{FILL A2g_SPECIFY}" if A2g > 0	**$_____**	**$_____**

B16. What services provided by this facility are included in the basic rate or provided at extra charge?	**Included in Basic Rate**	**Provided at Extra Charge**
a. (If B5a = "NO" go to B16b) Are special diets included in the basic rate or	**O**	**O**

provided at an extra charge?		
b. (If B5b = "NO" go to B16c) Is assistance with activities of daily living included in the basic rate or provided at an extra charge?	**O**	**O**
c. (If B5c = "NO" go to B16d) Is assistance with a bath or shower at least once a week included in the basic rate or provided at an extra charge?	**O**	**O**
d. (If B5d = "NO" go to B16e) Are skilled nursing services included in the basic rate or provided at an extra charge?	**O**	**O**
e. (If B5e = "NO" go to B16f) Is basic health monitoring, such as blood pressure and weight checks, included in the basic rate or provided at an extra charge?	**O**	**O**
f. (If B5f = "NO" go to B16g) Are social and recreational activities <u>within</u> the facility included in the basic rate or provided at an extra charge?	**O**	**O**
g. (If B5g = "NO" go to B16h) Are social and recreational activities <u>outside</u> the facility included in the basic rate or provided at an extra charge?	**O**	**O**
h. (If B5h = "NO" go to B16i) Is incontinence care included in the basic rate or provided at an extra charge?	**O**	**O**
i.. (If B5i = "NO" go to B16j) Is transportation to medical or dental appointments included in the basic rate or provided at an extra charge?	**O**	**O**
j. (If B5j = "NO" go to B16k) Is transportation to stores and elsewhere included in the basic rate or provided at an extra charge?	**O**	**O**
k. (If B5k = "NO" go to B16l) Is personal laundry included in the basic rate or provided at an extra charge?	**O**	**O**
l. (If B5l = "NO" go to B16m) Is linen laundry services included in the basic rate or provided at an extra charge?	**O**	**O**
m. (If B5m = "NO" go to B16n) Is social services counseling included in the basic rate or provided at an extra charge?	**O**	**O**
n. (If B5n = "NO" go to B16o) Is case management included in the basic rate or provided at an extra charge?	**O**	**O**
o. (If B5n = "NO" go to B16p) Is occupational therapy included in the basic rate or provided at an extra charge?	**O**	**O**
p. (If B5n = "NO" go to B16q) Is physical therapy included in the basic rate or provided at an extra charge?	**O**	**O**
q. (If B5n = "NO" go to B16r) Is transportation to a sheltered workshop, work training program or supported employment included in the basic rate or provided at an extra charge?	**O**	**O**
r. (If B5n = "NO" go to B16s) Is transprotation to an education program included in the basic rate or provided at an extra charge?	**O**	**O**

B16a1. (CAPI – IF B5a1 = YES then continue else go to B16a2)
Is cable TV service in the {CAPI: FILL "room" or "apartment" DEPENDENT ON WHAT FACILITY OFFERS} included in the basic rate or provided at an extra charge?

O INCLUDED IN BASIC SERVICE
O PROVIDED AT AN EXTRA CHARGE

B16a2. (CAPI – IF B5a2 = YES then continue else go to B16a3)

Is telephone service in the {CAPI: FILL "room" or "apartment" DEPENDENT ON WHAT FACILITY OFFERS} included in the basic rate or provided at an extra charge?

O INCLUDED IN BASIC SERVICE
O PROVIDED AT AN EXTRA CHARGE

B16a3. (CAPI – IF B5a4 = YES then continue else go to B17)
Is Internet service in the {CAPI: FILL "room" or "apartment" DEPENDENT ON WHAT FACILITY OFFERS} included in the basic rate or provided at an extra charge?

O INCLUDED IN BASIC SERVICE
O PROVIDED AT AN EXTRA CHARGE

B17. Are privately hired nurses, aides, or private duty nurses permitted to provide services to residents?

O YES
O NO

18. How many meals are included in the basic rate?

O ONE MEAL PER DAY
O TWO MEALS PER DAY
O THREE MEALS PER DAY
O NO MEALS PROVIDED

B19. Are residents required to eat during a scheduled meal time?

O YES
O NO

B20. Are residents required to eat meals in a specific location (e.g. dining room)?

O YES
O NO

B21. Does this facility have residents who speak limited or no English?

O YES
O NO – GO TO SECTION C

B22. How does staff communicate with these residents?

O Caregivers also speak their language
O Rely on family members to translate
O Use a translation service
O None of the above

C. Background of Administrator

The next questions are about the background of the facility administrator.

INTERVIEWER: ARE YOU SPEAKING WITH THE…

O HIGHEST RANKING ADMINISTRATOR/DIRECTOR OF THE RESIDENTIAL CARE PORTION OF THIS FACILITY

O SOMEONE OTHER THAN THE HIGHEST RANKING ADMINISTRATOR/DIRECTOR OF THE RESIDENTIAL CARE PORTION OF THIS FACILITY

{CAPI: ASK C1-C2 IF SPEAKING TO HIGHEST RANKING ADMINISTRATOR/DIRECTOR OF THE RESIDENTIAL CARE PORTION OF THIS FACILITY ELSE C3}

C1. How long have you worked at this facility as the administrator? Please include the cumulative time worked even if you have left the facility and then returned.
____ Years
____ Months

C2. How long, in total, have you worked at this and <u>other</u> residential care facilities or nursing homes in an administrative position?
____ Years
____ Months

C3. Do you have a certificate or license related to managing facilities for older people?
O YES
O NO
O DON'T KNOW

{CAPI: ASK C4-C6 IF SPEAKING TO SOMEONE OTHER THAN THE HIGHEST RANKING ADMINISTRATOR/DIRECTOR OF THE RESIDENTIAL CARE PORTION OF THIS FACILITY ELSE SECTION D}

C4. What position(s) do you hold at this facility? SELECT ALL THAT APPLY

☐ Owner/Operator

☐ Administrator/Manager/Director

☐ Supervisor-in-charge

☐ Wellness Director

☐ Director of Nursing

☐ Other: SPECIFY_____

C5. How long has the director/administrator worked at this facility as the administrator? Please include the cumulative time worked even if they have left the facility and then returned.
____ Years
____ Months

C6. Does the director/administrator have a certificate or license related to managing facilities for older people?
O YES
O NO
O DON'T KNOW

D. Demographics

{CAPI: IF SPEAKING TO HIGHEST RANKING ADMINISTRATOR/ DIRECTOR}: The final questions are about you. {CAPI: IF SPEAKING TO SOMEONE OTHER THAN HIGHEST RANKING ADMINISTRATOR/DIRECTOR}: Please answer the last few questions about the highest ranking administrator or director of this residential care facility.

D1. CAPI – IF SPEAKING TO THE HIGHEST RANKING ADMINISTRATOR / DIRECTOR: OBSERVE AND RECORD RESPONDENT'S GENDER. CAPI: IF SPEAKING TO SOMEONE OTHER THAN THE HIGHEST RANKING ADMINISTRATOR/DIRECTOR: Can you tell me the gender of the director or administrator?
O Male
O Female

D2. **SHOWCARD 10.** Please look at this card and tell me which range includes [your / the director's or administrator's] age.
O 18 – 29
O 30 – 39
O 40 – 49
O 50 – 59
O 60 – 69
O 70 or older

D3. [Are you/ Is the director/administrator] of Hispanic, Latino, or Spanish origin or descent?
O YES
O NO
O UNKNOWN

D4. **SHOWCARD 11.** Which of these groups best describe [you/the director/administrator]? You may select more than one category
☐ White/Caucasian
☐ Black or African American

☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native
☐ Other (SPECIFY)_____
☐ UNKNOWN

D5. **SHOWCARD 12.** What is the highest grade or level of education [you/the director/administrators] have/has completed?

O Less than high school
O High school graduate or GED
O Vocational, trade school, or technical school graduate
O Some college
O College graduate
O Post graduate
O UNKNOWN