Attachment P
National Resident Questionnaire

INSTRUCTIONS: SELECT SAMPLE OF RESIDENTS WITH SITE CONTACT. ONCE YOU HAVE SELECTED THE RESIDENTS, DETERMINE WHICH STAFF WILL BE COMPLETING A QUESTIONNAIRE ON EACH SELECTED RESIDENT.

In order to obtain national level data about the residents of residential care facilities such as this one, we are collecting information from a sample of current residents. I will be asking questions about the background, health status, and charges for each sampled resident.

The information you provide will be held in strict confidence and will be used only by persons involved in the survey and only for the purpose of the survey. This questionnaire should take about 20 minutes to complete per person.

Do you have the resident records for sampled resident number: {NUMBER OF SAMPLED RESIDENT) from the resident roster? You may want to use the resident file in answering a few of the questions in this survey. If you have not retrieved the records and would like to do so now, I can wait a few minutes while you obtain them.

REVIEW CONSENT WITH STAFF MEMBER

As discussed in the consent form, the information we are collecting will be kept confidential by project staff. The responses you provide will not be linked to any information that would identify you, the resident, or the facility. The only exception is that we will ask you for the first name or initials of the resident that was sampled. This will be used to personalize each question.

A. Background

Fname. What is the first name of the selected resident?
_____ FIRST NAME

A1. Please tell me {fill fname}'s gender:
O Male
O Female

A2. Please tell me {fill fname}'s age?
_____ AGE IN YEARS

{CAPI – IF A2 = 1 – 17 THEN GOTO ENDINT ELSE GOTO A3}

ENDINT. I am sorry but our survey is about residents that are 18 or older. Thank you for your time.

{CAPI - GOTO END OF INTERVIEW AND PROCEED TO SELECT AN ALTERNATE RESPONDENT}

A3. Is {fname} of Hispanic, Latino, or Spanish origin or descent?
O YES
O NO
O UNKNOWN

A4. **SHOWCARD 1.** Which of these groups best describe {fill fname}?
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

A5. What is the highest grade or level of education {fname} completed?
O High school or less
O Some college or more
O UNKNOWN

A6. Is {fill fname} currently married, divorced, legally separated, widowed or never married?
O Married
O Divorced
O Legally separated
O Widowed
O Never married
O UNKNOWN

A7. How well does {fill fname} speak English?
O Excellent
O Very well
O Well
O Fair
O Poor or not at all
O RESIDENT DOES NOT SPEAK BECAUSE OF A DISABILITY

A8. Is {fill fname} more comfortable communicating in English or another language?
O ENGLISH
O ANOTHER LANGUAGE

Living arrangement

The next few questions are about {fill fname}'s living arrangements.

For these questions, please consider this definition of an apartment. 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.

A9. {CAPI – IF {Facility Questionnaire} A5a, b, or c and A5d, e, or f > 0 else go to A9a}
[This means they offer apartments and rooms]

Does {fill fname} live in a…?
O Studio apartment
O One-bedroom apartment
O Two-bedroom apartment
O Room designed for one person
O Double-occupancy room
O Room for three or more residents

A9a. {CAPI – IF {Facility Questionnaire} A5a, b, or c > 0 else go to A9b}
[This means they offer apartments]

Does {fill fname} live in a…?
O Studio apartment

O One-bedroom apartment
O Two-bedroom apartment

A9b. {CAPI – IF {Facility Questionnaire} A5d, e, or f > 0 else go to A10}
[This means they offer rooms]

Does {fill fname} live in a…?
O Room designed for one person
O Double-occupancy room
O Room for three or more residents

A10. Does {fill fname} currently share this {CAPI: FILL "room/apartment"} with another person?
O YES
O NO – GO TO A13

A11. Is this person the resident's spouse or other relative? Other relative can include a sibling, a parent, child, or cousin.
O YES
O NO

{CAPI: IF A9 or A9b=ROOM AND YES TO A10 ELSE A13}:
A12. How many other residents not counting {fill fname} live in the room?
O One other resident
O Two or more other residents

A13. {CAPI: IF {Facility Questionnaire} = ALL DEMENTIA RESIDENTS Go to A14 else:}
Does {fill fname} live in a Dementia/Alzheimer's Special Care Unit?
O YES
O NO

{CAPI: IF A9 or A9a=APARTMENT CONTINUE, ELSE GOTO A15} A14. Does {fill fname}'s apartment include a kitchen area that contains…	YES	NO
a. a cook top or hotplate?	O	O
b. a microwave?	O	O
c. an oven?	O	O

A15. {CAPI: IF A9 or A9b=ROOM CONTINUE, ELSE GOTO A16}
Does {fill fname}'s room have a door to the hallway that can be locked?
O YES
O NO

A15a. Does {fill fname}'s room have a bathroom located inside the room?
O YES
O NO – GOTO A16

A15_Bath. Does {fill fname}'s room…	YES	NO
a. have a full bathroom including a toilet, sink, and shower or tub located within the room	**O** GOTO A16	**O**
b. have a half-bath including a sink and toilet located within the room	**O**	**O**

Activity involvement

A16. I am going to read a list of activities. Please tell me whether {fill fname} has participated in each activity during the past 7 days whether or not it is offered or arranged by the facility.

		YES	NO
a.	card, board games, bingo	**O**	**O**
b.	arts or crafts (e.g. sewing, knitting)	**O**	**O**
c.	exercise or sports	**O**	**O**
d.	playing or listening to music	**O**	**O**
e.	reading or writing	**O**	**O**
f.	spiritual or religious activities	**O**	**O**
g.	shopping or trips	**O**	**O**
h.	watching television	**O**	**O**
i.	walking or getting outside	**O**	**O**
j.	talking with friends or relatives	O	O
k.	going out to the movies or other social activities	O	O

A16_outside. Does {fill fname} go outside the facility to		YES	NO
a.	work at a job for pay	O	O
b.	participate in a sheltered workshop	O	O
c.	participate in a work training program	O	O
d.	to attend day programs for social or recreational activities	O	O
e.	to attend an educational program	O	O

A17. {CAPI: IF SCREENING QUESTIONNAIRE (S3C = ALL DEMENTIA RESIDENTS AND DEMENTIA UNITS Go to B1 else:} Does {fill fname}drive?

O YES
O NO – GO TO B1

A18. How often does {fill fname} drive?

O Daily or every other day
O Once or twice a week
O Less than once per week

O Not at all

B. Resident Characteristics

The next few questions are about resident characteristics.

Length of time in facility / date of admission

THESE QUESTIONS MAY REQUIRE THAT THE RESPONDENT LOOK TO THE RESIDENT'S RECORDS. IF THE RESPONDENT HAS THE RECORDS ON HAND – PROMPT THEM TO ACCESS THESE AS NEEDED FOR THE NEXT FEW QUESTIONS.
B1. When did {fill fname} first move into to this facility?
_____ Month
_____ Year

INT: IF RESPONDENT DOES NOT KNOW MONTH AND YEAR ASK:

B1a. **SHOWCARD 2.** Please look at this card and tell me approximately how long it has been since {fill fname} first moved into to this facility?
O 0 to 3 months
O More than 3 months to 6 months
O More than 6 months to 1 year
O More than 1 year to 3 years
O More than 3 year to 5 years
O More than 5 years

B2. Was {fill fname} admitted directly from a short-term stay at a:
O Hospital
O Rehabilitation facility
O Nursing home
O NONE OF THE ABOVE

B3. **SHOWCARD 3.** Where did {fill fname} live prior to {CAPI: Fill from B2 "a short term stay at a hospital, rehabilitation facility, nursing home else:{entering this facility}? Was it a…
O Private home/apartment/rented room/family residence
O Different residential care/assisted living/group home facility
O Retirement/independent living community
O Nursing home (this excludes short nursing home stays for rehabilitation)
O Other (specify):_____

B4. For last month, what was the total charge for {fill fname} to live in this facility? Include the basic monthly charge and charges for any additional services.
_____ AMOUNT IN DOLLARS PER MONTH

Source of Payment (e.g., private funds / Medicaid

B5. During the last 30 days, did {fill fname's} have some or all of [his/her] long-term care services at this facility paid by Medicaid?_____

O YES
O NO

B6. Is {fill fname's} a veteran of U.S. military service?

O YES
O NO

C. Health Status and Physical Functioning

The next few questions are about {fill fname}'s health status and physical functioning.

Physical health/health conditions

C1. **SHOWCARD 4.** As far as you know, has a doctor or other health professional ever diagnosed {fill fname} with any of the following conditions: Check all that apply.

a.	Diabetes	O
b.	Partial or total paralysis	O
c.	Alzheimer's disease or other dementia	O
d.	Arthritis or rheumatoid artritis	O
	Gout, lupus, or fibromyalgia	O
e.	High blood pressure or hypertension	O
f.	Congestive heart failure	O
g.	Coronary heart disease	O
h.	Heart attack (myocardial infraction)	O
i.	Any other kind of heart condition or heart disease (other than listed above)	O
j.	Stroke	O
k.	Kidney disease	O
l.	Cancer or malignant neoplasm of any kind	
	Bladder	O
	Blood	O
	Bone	O
	Brain	O
	Breast	O
	Cervix	O
	Colon	O
	Esophagus	O
	Gallbladder	O
	Kidney	O
	Larynx-windpipe	O

Leukemia	O	
Liver	O	
Lung	O	
Lymphoma		O
Melanoma	O	
Mouth/tongue/lip	O	
Ovary	O	
Pancreas	O	
Prostate	O	
Rectum	O	
Skin (non-melanoma)		O
Skin (DK what kind)	O	
Soft tissue (muscle or fat)	O	
Stomach	O	
Testis	O	
Throat – pharynx	O	
Thyroid	O	
Uterus	O	
Other	O	
Refused	O	
Don't know	O	
m. Asthma	O	
n. emphysema	O	
o. chronic bronchitis	O	
p. COPD	O	
q. Cerebral Palsy	O	
r. Muscular Dystrophy	O	
s. Osteoporosis	O	
t. Nervous system disorders, including multiple sclerosis, Parkinson's disease, and epilepsy	O	
u. Serious mental problems such as schizophrenia or psychosis. Depression	O	
v. Other mental, emotional, nervous condition, or depression	O	
w. Intellectual or developmental disabilities such as mental retardation, severe autism, or Down syndrome	O	
x. Spinal cord injury	O	
y. Traumatic brain injury	O	
z. Other: SPECIFY: _____	O	

C1_impair. Which statement best describes {fill fname} hearing without a hearing aid?:

O good
O a little trouble
O a lot of trouble
O deaf

C1_impair. Does {fill fname} have any trouble seeing even when wearing glasses or contact lenses? OYes O No

C1_impair. Is {fill fname} blind or unable to see?
OYes O No

C2. . If B1< 12 MONTHS, then, "The next question refers to the [CAPI – number] of months since {fill fname} moved into this residential care facility." If B1>= TO 12 MONTHS, then "The next question refers to the last 12 months." During this time, has {fill fname}:

		YES	NO
a.	been treated in a hospital emergency room	O	O
b.	been a patient in a hospital overnight or longer – excluding trips to the emergency room that did not result in a hospital stay	O	O
c.	had a stroke	O	O
d.	had a heart attack	O	O
e.	had a fall that caused a hip fracture	O	O
f.	had a fall that caused an injury other than a hip fracture	O	O
g.	had a short-term stay in a nursing home	O	O
h.	Other health emergency: SPECIFY_____	O	O

C3.. IF YES TO C2a CONTINUE, ELSE GO TO C4: If B1< 12 MONTHS, then, "The next question refers to the [CAPI – number] of months since {fill fname} moved into this residential care facility." If B1>= TO 12 MONTHS, then "The next question refers to the last 12 months." How many times has {fill fname} been treated in a hospital emergency room over this period?
_____ TIMES

C4. Does {fill fname} currently use any of the following:

		YES	NO
a.	Dentures (includes a partial plate)	O	O
b.	Glasses or contact lenses	O	O
c.	Hearing aid	O	O
d.	Cane (includes tripod cane)	O	O
e.	Walker	O	O
f.	Manual wheel chair	O	O
g.	Electric/motorized wheel chair	O	O
h.	Oxygen	O	O
i.	Communication board or other appliance to communicate	O	O
j.	Artificial limb	O	O

C4a. {IF C1m=YES CONTINUE ELSE C14}
Does{fill fname}now use telescopic lenses, Braille, readers, a guide dog, white cane, or any other equipment for people with severe visual impairments?
O YES
O NO

Cognitive status

C5a. Is {fill fname} LIMITED IN ANY WAY because of difficulty remembering or because{fill fname} experiences periods of confusion?

O YES
O NO

C5b. During the last 7 days, has {fill fname} given evidence of a problem with short-term memory, such as difficulty remembering what he/she had for breakfast or something you told him/her a few minutes earlier?

O YES
O NO

C6. During the last 7 days, has {fill fname} given evidence of a problem with long-term memory, such as forgetting how old he/she is or forgetting that he/she was married?

O YES
O NO

C7. During the last 7 days, has {fill fname} had problems with orientation, such as:

		YES	**NO**
a.	Knowing the location of his/her bedroom?	**O**	**O**
b.	Recognizing staff names/faces?	**O**	**O**
c.	Knowing that he/she is in a facility?	**O**	**O**
d.	Knowing what the season of the year is?	**O**	**O**

C8. During the last 7 days, which of the following best describes {fill fname}'s decision-making about such things as what to wear, how to organize his/her day, etc? Would you say…

O Independent - decisions were consistent, reasonable
O Modified independence – he or she had some difficulty in new situations
O Moderately impaired – his or her decisions were poor; cues and supervision were required
O Severely impaired- he or she never or rarely made decisions

C9. During the last 7 days, which of the following best describes {fill fname}'s ability to make [himself/herself] understood by others?

O Always understood by others – GOTO C10.
O Usually understood - difficulty finding words or finishing thoughts
O Sometimes understood - ability is limited to making concrete requests
O Rarely or never understood

C9a. Is {fill fname}'s difficulty in making [himself/herself] understood by others due to a severe speech impairment or other disability?

O YES
O NO

Physical functioning (ADL / IADL status)

C10. Next, I would like to ask about everyday activities and whether {fill fname} receives any assistance in doing them. "By assistance, I mean help from special equipment, supervision or cueing by another person, or hands-on assistance performing the task."

	YES	NO	
a. Does {fill fname} currently receive assistance in bathing or showering?	O	O	**a1. IF YES:** Does {fill fname} bathe or shower with the help of: 1. Special Equipment **OYES ONO** 2. Another Person **OYES ONO**
b. Does {fill fname} currently receive assistance in dressing?	O	O	**b1. IF YES:** Does {fill fname} dress with the help of: 1. Special Equipment (Example: Zipper pulls or button hook aids) **OYES ONO** 2. Another Person **OYES ONO**
c. Does {fill fname} currently receive assistance in eating? (e.g. cutting up food)	O	O	**c1. IF YES:** Does {fill fname} eat with the help of: 1. Special Equipment **OYES ONO** 2. Another Person **OYES ONO**
d. Is {fill fname} confined to bed by health problems?	O	O	
e. Is {fill fname} confined to a chair by health problems?	O	O	
f. Does {fill fname} currently receive any assistance in transferring in and out of bed or a chair?	O	O	**f1. IF YES:** Does {fill fname} require the help of: 1. Special Equipment **OYES ONO** 2. Another Person **OYES ONO**
g. Does {fill fname} currently receive any assistance in walking?	O	O	**g1. IF YES:** Does {fill fname} walk with the help of: 1. Special Equipment **OYES ONO** 2. Another Person **OYES ONO**
h. Does {fill fname} go off the grounds of this facility?	O	O	**h1. IF YES:** When {fill fname} goes outside the grounds does {fill fname}require the help of: 1. Special Equipment **OYES ONO** 2. Another Person **OYES ONO**
i. Does {fill fname} have an ostomy, an indwelling catheter or similar device?	O	O	**i1. IF YES:** Does {fill fname} receive any help from another person in caring for this device? **OYES ONO**

j. Does {fill fname} currently receive any assistance using the bathroom? O YES O NO O Does not use toilet (ostomy patient, chairfast, etc.)			**j1. IF YES:** Does {fill fname} require the help of: 1. Special Equipment **OYES ONO** 2. Another Person **OYES ONO**
k. Has {fill fname} had any episode of bowel incontinence during the last 7 days? O YES O NO O NOT APPLICABLE (e.g. had a colostomy)	**O**	**O**	
l. Has {fill fname} had any episode of urinary incontinence during the last 7 days? O YES O NO O NOT APPLICABLE (e.g. has an indwelling catheter, had a ostomy)	**O**	**O**	
m. Is {fill fname} able to get out of the facility without help in case of an emergency?	**O**	**O**	

For the next question, please respond yes, no, or does not perform this activity. **C11. Does {fill fname} currently need help from another person with the following activities:**	**YES**	**NO**	**DOES NOT PERFORM THIS ACTIVITY**
a. Shopping for personal items, such as toilet items or medicine?	**O**	**O**	**O**
b. Managing money, such as keeping track of expenses or paying bills?	**O**	**O**	**O**
c. Using the telephone – This includes help provided from another person or a special device such as TTY C11c_1. {IF C11c=YES CONTINUE ELSE GOTO C11d} Does {fill fname} receive help using the telephone from another person or a special device? **O** ANOTHER PERSON **O** SPECIAL DEVICE **O** BOTH	**O**	**O**	**O**

d. Doing light housework, like straightening up his or her room or apartment?	O	O	O
e. Taking medication (this includes opening the bottle, remembering to take medication on time, and taking the prescribed dosage)?	O	O	O

C12 {IF C1n=YES OR IF C1_speech = YES CONTINUE ELSE C13a}
Does{fill fname}now use an amplifier for the telephone, a TDD, TTY or teletype, closed caption TV, assistive listening or signaling devices, an interpreter, or any other equipment for people with hearing or speech impairments?

O YES {CAPI: SKIP TO C13}
O NO

C12a. Does {fill fname} have a landline telephone or cellular telephone in his/her room?
O YES
O NO
O DON'T KNOW

Health Status and Limitations

CX. Without assístance and without equipment, how difficult is it for {fill fname) to

…Walk a quarter mile – about 3 city blocks?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Walk up 10 steps without resting?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Stand or be on feet for about 2 hours?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Sit for about 2 hours?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Stop, bend, or kneel?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Reach up over head?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused

7 don't know

…Use fingers to grasp or handle small objects?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Lift or carry something as heavy as 10 pounds such as a full bag of groceries?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Push or pull large objects like a living room chair?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

…Go out to things like shopping, movies, or sporting events?

0 not at all difficult
1 only a little difficult
2 somewhat difficult
3 very difficult
4 can't do at all
5 do not do this activity
6 refused
7 don't know

Psychosocial wellbeing

C13. Over the last 30 days, how often did {fill fname} receive one or more outside visitors? Would you say…

O every day
O at least several times a week
O about once a week
O several times during the past 30 days but less than every week
O at least once in the last 30 days.
O none at all in the last 30 days

Behavioral Problems **(Deleted – b. Consuming excessive amounts of alcohol)**

C14. In the past 30 days, how often has {fill fname} exhibited any of the following behaviors?	**Often**	**Some times**	**Never**	**DK**
a. Refusing to take prescribed medicines at the appropriate time or in the prescribed dosage.	**O**	**O**	**O**	**O**
b. (deleted)				
c. Creating disturbances or being excessively noisy by knocking on doors, getting lost, or moving aimlessly in the building or grounds	**O**	**O**	**O**	**O**
d. Refusing to bathe or clean oneself	**O**	**O**	**O**	**O**
e. Rummaging through or taking other people's belongings	**O**	**O**	**O**	**O**
f. Damaging or destroying property	**O**	**O**	**O**	**O**
g. Verbally threatening other persons including staff or other residents	**O**	**O**	**O**	**O**
h. Being physically aggressive towards other persons including staff or other residents	**O**	**O**	**O**	**O**
i. Removing clothing in public	**O**	**O**	**O**	**O**
j. Making unwanted sexual advances towards staff or other residents	**O**	**O**	**O**	**O**

{CAPI: IF C14a, C14b, C14c, C14d, C14e, C14f, C14g, C14h, C14i, or C14j = "Often" or "Sometimes" then C15, else C16}

C15. Does a physician ever prescribe medications to help control {fill fname}'s behavior or to reduce agitation?

O YES
O NO

Types of services used

C16. Does {fill fname} currently use any of the following services?	**YES**	**NO**
a. {CAPI – fill services from B5 of facility questionnaire if the service was provided by facility staff or at facility by non-facility staff	O	O
b. {CAPI – fill services from B5 of facility questionnaire if the service was provided by facility staff or at facility by non-facility staff	O	O
c. {CAPI – fill services from B5 of facility questionnaire if the service was provided by facility staff or at facility by non-facility staff	O	O
d. Etc…	O	O
e. Etc…	O	O

The next few questions are about you.

C17. How long have you worked at this facility?
[ ] Months
[ ] Years

C18. **SHOWCARD 5.** Please look at this show card and tell me which best describes your position at this facility.
O RN
O LPN
O Certified medication aide or supervisor
O Personal care aide
O Activity director/staff
O Owner, administrator, director, or manager

Thank you. These are all the questions I have for you.

End of interview.

Debriefing Questions.

FI: PLEASE COMPLETE THE FOLLOWING QUESTIONS BEFORE LEAVING THE FACILITY.

Debrief1. Did the administrator have the advance data collection form filled out?
O YES
O NO Please explain: [allow 100]

Debrief2. Did respondents have any specific difficulties answering any questions?
O YES Please explain: [allow 100]
O NO

Debrief3. Do you feel respondents were accurate in their answers?
O YES
O NO Please explain: [allow 100]

Debrief4. How many respondents were needed to complete the facility questionnaire?
_____ {CAPI: IF > 1 then: Please explain: [allow 100]}

Debrief5. How long were you at this facility, from the time you arrived until the time you left or will leave.
Hours_____ Minutes_____ {CAPI HOURS MAX=8 MINUTES MAX=90}

Debrief6. Please describe any difficulty staff had obtaining resident records:__ [allow 150]

Debrief7. Please describe any difficulty staff had finding or locating information within resident records: _____ [allow 150]

Debrief8. Enter other comments about this facility, respondents, or data collected not mentioned above: _____ [allow 150]

Debrief9. Please describe any difficulty in locating the correct staff person to complete the interview. _____[allow 150]