Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

ASSISTED LIVING PROVIDER INFORMATION TOOL FOR CONSUMER EDUCATION

Developed by the Assisted Living Collaborative

This tool is intended for communities that meet the following definition of "assisted living":

"Assisted living" refers to residential long-term care options that are licensed, certified, or registered by states as assisted living or other residential care names, such as board and care. They combine housing and supportive services, which include at a minimum, assistance with activities of daily living and/or health care (such as help with medication administration). Assisted living settings have on-site staff available to meet both scheduled and unscheduled needs for assistance 24 hours per day, seven days per week. They also offer dining (two or more meals per day) and a variety of supportive services related to social and wellness activities. They care for individuals with a range of functional needs including dementia, and may provide a dedicated wing/area with additional security and cueing devices among other special services for those individuals. Assisted living rooms/apartments may be offered in freestanding communities or in a separate wing or building in a long-term care campus that provides other types of care.

For purposes of this tool, assisted living does not include residential long-term care options that are licensed, certified, or registered by states as nursing homes, or to exclusively serve persons with intellectual and developmental disabilities, mental illness (which is different than dementia), or substance use disorders.

If your community does not meet this definition of assisted living, please do not complete this tool. Instead, check this box and return the blank tool in the enclosed envelope: ☐

While completing this tool, please consider the following information:

- This information tool should take approximately 25 minutes to complete.
- This tool should be completed by the individual who is the most knowledgeable about the community's operations, most typically, the Administrator or Executive Director. If the individual completing the tool is not the most knowledgeable, it is advisable if other staff review the responses to ensure they are correct.
- The items on this tool relate only to your assisted living community and the assisted living rooms/apartments, even though some assisted living communities include nursing home or independent living rooms/apartments.
- Answer the questions in reference to your entire assisted living community unless otherwise instructed. Some assisted living communities offer specialized care, such as dementia care. If your assisted living community offers more than one type of assisted living care (e.g., a portion of the community that is set aside for dementia care), answer the questions in reference to the entire community, unless otherwise instructed.
- All questions should be completed in reference to current operations, as of the date the tool is completed.
- Complete these questions only in reference to the community located at the address to which this tool was mailed. If you or your organization owns or operates more than one assisted living community, complete the information tool in reference to the community identified in the mailing address. If the address to which this tool was mailed is not the correct address for one of your organization's assisted living communities, please call 1-XXX-XXX-XXXX to clarify this matter.
- Your responses to this tool are provided voluntarily and all of your answers will be kept confidential. If you have any questions about this tool, please call _____ at 1-XXX-XXX-XXXX.

Please place an "X" over the circle to indicate your answer, like this: 
If you are unsure about how to answer a question, please give the best answer you can.

- Please answer each question unless you are asked to skip to another question.
- Select only one answer for each question unless you are asked to "Indicate all that apply".
- It is best to use a soft lead pencil in case you want to change an answer.
- When you are finished, please place the tool in the enclosed postage-paid envelope and put it in the mail.

Abt SRBI ID # XX-XXX

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A. Description of Assisted Living Community

A1. **Please answer these descriptive questions about your assisted living community:**

a. Community Name:

b. Address:

c. City: State: Zip:

d. County:

e. Telephone Number: ( ) -

A2. a. **Does your community have a website?**

O Yes → What is the website address?

O No

b. **Does your community have an e-mail address to which prospective residents and families can send comments and questions?**

O Yes → What is the e-mail address?

O No

A3. **Is your community licensed/registered/certified by the state to provide residential and supportive services?**

O Yes
O No

A4. **Which of these categories describes your community's ownership?** ***SELECT ONE ANSWER***

O For profit
O Not for profit
O City/county/state government
O Other → Specify: _____

A5. ***This question asks about resident rooms/apartments. A room/apartment is the area dedicated to the use of one or more residents, set off from common spaces by a door. So, if an apartment is set off from the common space by a door, it counts as one room/apartment, even if the apartment itself has more than one room.*** **How many assisted living rooms/apartments are in your community?**

Number of rooms/apartments:

A6. **Do all of your assisted living rooms/apartments have these features?** ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. A private toilet	O	O
b. A private shower or bathtub	O	O
c. An entry door that locks	O	O

A7. **Does your assisted living community have a dementia neighborhood or unit (whether or not it is locked), meaning all or a section of the building that is dedicated to serving persons with Alzheimer's Disease and other dementias?**

O Yes O No

A8. Are the following types of services provided at the **same location (same address or campus), regardless of whether or not it is in the same building?** ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Independent living/independent apartments	O	O
b. Nursing home beds	O	O
c. Hospital	O	O
d. Other → Specify: _____	O	O

A9. **Is your assisted living community part of a continuing care retirement community (CCRC)?**

O Yes O No

B. Move In and Move Out Processes

These questions ask about the move in and move out processes used by your community.

Many assisted living communities collect a variety of different fees during the move-in process. While the names used for these vary from place to place, the next few questions are designed to obtain information on what your community does in this regard.

B1. **Does your community require these for move-in?** ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**	**Sometimes**
a. A reservation fee to be on a waiting list or to reserve a room/apartment	O	O	O
	O	O	O
b. A one-time, partially refundable or non-refundable entrance or community fee	O	O	O
c. A security deposit to cover damages	O	O	O
d.. Other deposits (e.g., pets, smoking)	O	O	O
e. Last month's "rent"	O	O	O

B2. Does your community require a resident to have a recent medical evaluation (by a nurse or physician) as part of the move-in process?

O Yes O No

B3. **The following questions ask about whom you accept to move in, and whom you will retain in your community. For each of the areas, please indicate:**

(1) If your community generally allows a person to move in who routinely needs staff assistance (such as one-on-one monitoring or physical assistance) in that area; and

(2) If your community generally retains a resident who routinely needs staff assistance (such as one-on-one monitoring or physical assistance) in that area.

SELECT ONE ANSWER FOR QUESTION (1) AND ONE ANSWER FOR QUESTION (2) FOR EACH ROW

	(1) Will your community generally allow a person to move in who routinely needs staff to assist with…	**(2) Will your community generally retain a resident who routinely needs your staff to assist with…**
a. Evacuating in an emergency	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
b. Toileting	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
c. Incontinence care (bladder)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
d. Incontinence care (bowel)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
e. Bathing	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
f. Dressing	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
g. A two-person transfer between bed and chair or wheelchair	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
h. Transferring from bed to chair or wheelchair (but less than a two-person transfer)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
i. Eating (such as cutting up food or providing special set-up or devices)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge

	(1) Will your community generally allow a person to move in who routinely needs staff to assist with…	**(2) Will your community generally retain a resident who routinely needs your staff to assist with…**
j. Dining (hands-on assistance with eating)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
k. Care of Stage 1 or 2 pressure sores	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
l. Oxygen that needs a nurse or other trained staff to calibrate/manage	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
m. PRN (as needed) medications	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
n. Injectable medications such as insulin	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
o. An indwelling catheter	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
p. Tube feeding	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge

B4. These next items ask:

(1) If your community generally allows people with the following needs to move in; and

(2) If your community generally retains a resident with the following needs.

SELECT ONE ANSWER FOR QUESTION (1) AND ONE ANSWER FOR QUESTION (2) FOR EACH ROW

	(1) Will your community generally allow a person to move in who…	**(2) Will your community generally retain a resident who. . .**
a. Uses oxygen which the resident can manage him/herself	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
b. Administers his/her own injectable medication, such as insulin	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
c. Is enrolled in Hospice	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
d. Has poor safety awareness (for example, wanders or requires constant supervision)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
e. Exhibits difficult or disruptive behaviors	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
f. Has a primary diagnosis of an intellectual or developmental disability (e.g., Down's Syndrome)	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
g. Has a primary diagnosis of a psychiatric disorder, other than Alzheimer's disease or other dementia	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge
h. Uses a Hoyer or other mechanical lift for transferring	O Yes O No O No, state prohibits	O Yes O Maybe, with outside services and/or other special circumstances O No, requires discharge

C. Service Provision

C1. Please indicate how your community's recurring monthly fees are set. INDICATE ALL THAT APPLY.

- O Number of different services that are grouped together in tiers
- O Fees for specific services (a la carte pricing)
- O Minutes for specific services, such as the amount of time required to assist with dressing
- O Points for specific services, such as based on the need for assistance with dressing
- O Other
- O None of the above, community has an all-inclusive flat rate with no additional charges

C2. **For each of these services, please indicate whether it is:** • **offered; part of the basic package (base rate) of services; or** • **offered; may be an additional fee; or** • **not offered** ***SELECT ONE ANSWER FOR EACH ROW***	**Offered, basic package**	**Offered, may be an additional fee**	**Not offered**
a. **Personal care and assistance**			
(1) For dressing and grooming	O	O	O
(2) For mobility (walking and wheelchair use)	O	O	O
(3) For transferring (bed to chair or wheelchair)	O	O	O
(4) For eating, such as cutting food or providing special set-up or devices	O	O	O
(5) For dining (hands-on assistance with eating)	O	O	O
(6i) For bathing twice a week or less	O	O	O
(6ii) For bathing more than twice a week	O	O	O
b. **Toileting and incontinence care**			
(1) Reminders, assistance, and supervision with toileting	O	O	O
(2) Managing supplies, assisting in use of supplies, doing related cleaning and laundry	O	O	O
(3) Assistance with catheter care	O	O	O
(4) Assistance with ostomy care	O	O	O
c. **Housekeeping at least weekly**, including vacuuming, emptying trashcans, cleaning the bathroom, and changing the bed	O	O	O
d. **Linen service (bed linen and towels) at least weekly**,	O	O	O
e. **Personal laundry (clothing) at least weekly**	O	O	O
f. **Meals available at non-scheduled times**	O	O	O
g. **Prescribed and special diets, such as diabetic ormechanical soft**	O	O	O
h. **Health care services** (1) Regularly scheduled assessment of resident health, function, and cognition by a licensed nurse (RN, LPN, LVN) after move-in	O	O	O
(2) Assessment of skin integrity by a licensed nurse as needed	O	O	O
(3) Vital sign/wellness monitoring, such as blood pressure, weight, pulse, temperature, respiration	O	O	O

C2. **For each of these services, please indicate whether it is:** • **offered; part of the basic package (base rate) of services; or** • **offered; may be an additional fee; or** • **not offered** ***SELECT ONE ANSWER FOR EACH ROW***	**Offered, basic package**	**Offered, may be an additional fee**	**Not offered**
(i) at least monthly			
(ii) more often than monthly	O	O	O
(4) Finger stick glucose testing as needed	O	O	O
(5) Oxygen use/equipment management	O	O	O
i. **Medications** (1) Staff set-up medications in pill organizers	O	O	O
(2) Staff prepare medications such as mixing, crushing, or dissolving medications	O	O	O
(3) Staff pass medications	O	O	O
(4) Staff give injections	O	O	O
j. **Transportation for medical appointments** (1) During designated times only	O	O	O
(2) As requested	O	O	O
(3) With an escort	O	O	O
(4) Within a set distance	O	O	O
(5) Beyond a set distance	O	O	O
k. **Transportation for non-medical reasons**, such as to social/cultural/religious activities (1) During designated times only	O	O	O
(2) As requested	O	O	O
(3) With an escort	O	O	O

C3. **Does your community have contracts or established arrangements with the following professionals to visit and provide services to residents on-site?** ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Physician, nurse practitioner, or physician's assistant	O	O
b. Podiatrist	O	O
c. Dental hygienist	O	O
d. Dentist	O	O
e. Optometrist	O	O
f. Audiologist	O	O
g. Physical, occupational, or speech therapist	O	O
h. Licensed clinical mental health provider	O	O

C4. ***The next questions relate to recreational services, support/education, and social setting:*** ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Does your community provide scheduled group activities (1) at least twice a day during the week?	O	O
(2) at least twice a day on weekends?	O	O
b. Does your community develop individualized activity plans?	O	O
c. Does your community have resident support/education groups related to wellness, managing chronic health conditions such as dementia or diabetes, or other topics?	O	O
d. Does your community have family support/education groups related to wellness, managing chronic health conditions such as dementia or diabetes, or other topics?	O	O
e. Does your community have a resident council?	O	O
f. Does your community have a family council?	O	O
g. Does your community provide personal mailboxes for each resident?	O	O
h. Does your community have any community pets (such as dogs, cats, rabbits, fish, or birds) meaning pets whose care is not the responsibility of an individual resident?	O	O

C5. **Which of these activities does your community offer, either to the community at large and/or designed for residents with dementia?** ***INDICATE ALL THAT APPLY FOR EACH ROW***	**Yes, offered to community at large**	**Yes, designed for residents with dementia**	**Not offered at all**
a. Spiritual/religious	O	O	O
b. Physical activity, such as weight-lifting, swimming, yoga, or Wii Sports	O	O	O
c. Music activity/therapy	O	O	O
d. Tactile and sensory-related activities	O	O	O
e. Reminiscence	O	O	O

D. Policies

D1. ***These questions relate to medications:*** ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Is an assessment done (by your staff or someone else) regarding a resident's ability to self-administer medications independent of staff assistance?	O	O
b. Does your community or state prohibit **all** residents from keeping *prescribed medications* in their rooms?	O	O
c. Does your community or state prohibit **all** residents from keeping *over-the-counter medications* in their rooms?	O	O
d. Does your community or state prohibit **all** residents from self-administering their	O	O

prescribed medications independent of staff assistance?		
e. Does your community or state prohibit **all** residents from self-administering their *over-the-counter* medications independent of staff assistance?	O	O
f. Does your community offer regular review of medications by a nurse or pharmacist?	O	O
g. If a resident wants to use a pharmacy other than those with which you contract, will you help coordinate this?	O	O
IF YES: (1) Is there an additional fee for arranging this individualized service?	O	O
(2) Do these restrictions apply? (a) Pharmacy must package medications in accordance with community packaging requirements	O	O
(b) Delivery of medication must be available on an emergency basis	O	O

D2. Does your community or state prohibit all residents from: ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Smoking?		
(1) in rooms/apartments	O	O
(2) in designated areas in the building	O	O
(3) on the grounds	O	O
b. Keeping/consuming alcoholic beverages in their rooms?	O	O
c. Consuming alcoholic beverages in common areas, such as the dining room?	O	O
d. Keeping a cat, dog, or other pet in their room/apartment?	O	O

D3. Does your community have a written policy in these areas? ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Resident rights (as per state law)	O	O
b. Fire evacuation plan	O	O
c. Emergency plan	O	O
d. Missing person or elopement policy	O	O
e. Involuntary discharge procedures including appeals	O	O
f. Community's rules	O	O
g. Grievance procedures	O	O
h. Advance directives	O	O
j. Restraints and restraint alternatives	O	O
k. Visitation, such as who can visit or related to visiting hours or overnight guests	O	O
l. Conjugal visits	O	O

E. Charges and Payments

Some assisted living communities offer different types of rooms/apartments as well as private and shared rooms.

E1. For each type of room/apartment that your community has, whether in a dementia neighborhood or not, what is the (1) size, and (2) monthly rental fee if occupied by <u>one</u> person? If you do not have that type of room/apartment, indicate N/A (not applicable).

	(1) Square footage (range)	(2) Monthly rental fee (range)
a. 2 Bedroom apartment (includes private bath and kitchenette) O N/A	____ sq. ft. to ____ sq. ft.	$_____ to $_____
B. 1 Bedroom apartment (includes private bath and kitchenette) O N/A	____ sq. ft. to ____ sq. ft.	$_____ to $_____
c. Studio/Efficiency room/apartment (includes private bath and kitchenette) O N/A	____ sq. ft. to ____ sq. ft.	$_____ to $_____
d. Private room (excludes kitchenette, includes private bath) O N/A	____ sq. ft. to ____ sq. ft.	$_____ to $_____
e. Private room (excludes kitchenette and bath) O N/A	____ sq. ft. to ____ sq. ft.	$_____ to $_____

Note: Monthly rental fee may include some supportive and/or health-related services. This information is asked earlier in Section C.

E2. For a semi-private room (a room shared by two strangers and with no kitchenette), what is the (1) room size and (2) the <u>per person</u> monthly rent?

	(1) Square footage (range)	(2) Monthly rental fee (range)
a. Semi private room (excludes kitchenette) O N/A	____ sq. ft. to ____ sq. ft.	$_____ to $_____

The next questions are about public payment.

E3. ***Regarding public payment:*** **SELECT ONE ANSWER FOR EACH ROW**	**Yes**	**No**
a. Does your community accept Medicaid for prospective (i.e., newly moved in) residents? *Medicaid may have another name in some states, such as Medi-Cal, MassHealth, Oregon Health Plan, or TennCare.*	O	O
b. Does your community accept Medicaid for existing residents who have spent down?	O	O
c. Is there generally a wait list for residents with Medicaid?	O	O
d. Does your community accept other public assistance, such as Veterans Aid and Attendance or state-funded subsidies?	O	O

F. Staffing

The next questions ask about nurse staffing (RNs, LPNs, LVNs) in your community. Indicate all that apply.

	On-site 24/7	On-site at least 35 hrs/wk	On-site less than 35 hrs/wk	On call	Do not use
F1. How often does your community use registered nurse(s (RNs)? ***INDICATE ALL THAT APPLY*** a. **IF ON-SITE**: Does your community staff fewer RNs during the weekends than during the week? O Yes O No	O	O	O	O	O
F2. How often does your community use licensed practical nurse(s) (LPNs) or licensed vocational nurse(s) (LVNs)? ***INDICATE ALL THAT APPLY*** a. **IF ON-SITE**: Does your community staff fewer LPNs/LVNs during the weekends than during the week? O Yes O No	O	O	O	O	O

The next questions are about the nurses and other care staff in your community.

SELECT ONE ANSWER FOR EACH ROW	Yes	No
F3. Is at least one staff member (personal care assistant, or CNA, or RN, or LPN, or LVN):		
a. On-site 24 hours a day, 7 days a week?	O	O
b. Required to be awake at all times?	O	O
F4. Does your community have a Medical Director?	O	O
F5. Does your community require criminal background checks for all new employees?	O	O
F6. Does your community have someone on staff who is professionally trained (such as a social worker) to help families and residents deal with psychosocial issues such as challenges of aging, transitions to and within the community, and dementia?	O	O

F7. **These questions relate to staff training. Please indicate which staff receives training in the following areas:** ***INDICATE ALL THAT APPLY FOR EACH ROW***	RN/LPN/LVN	Personal care assistants, CNAs	Other staff	No staff
a. **Resident care and services** (such as ADL care, rights and responsibilities, abuse and neglect, confidentiality, transitions of care)	O	O	O	O
b. **Safety** (such as food handling and safety, infection control, first aid/CPR, fire emergency and preparedness)	O	O	O	O
c. **Age-related changes** (such as incontinence, falls, malnutrition, hearing/vision, thinning bones, sleep problems)	O	O	O	O
d. **Dementia** (such as person-centered caring, communication training, behavior management, psycho-social needs of population)	O	O	O	O

e. **Service delivery practices** (such as communication training, team building, person-centered care, cultural competency, customer service, family support)	O	O	O	O
f. **Medication management** (such as types of administration, storage, documentation, re-ordering)	O	O	O	O
g. **Palliative and end-of-life care** (such as advance directives, pain control, and grief and loss)	O	O	O	O

G. Environment

The next questions ask about different components of your community's environment. ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**	**Not applic-able**
G1. Do residents live on three or more floors (also known as stories) in your building?	O	O	O
G2. Is the front door secured by a keypad or other safety locking device that prevents persons at risk of elopement from leaving?	O	O	O
G3. Does your community have these common spaces available for use by residents and families? a. A private dining room	O	O	O
b. A kitchen	O	O	O
c. A secure outdoor space for activities	O	O	O
d. A designated smoking area	O	O	O
G4. Does your community have special environmental adaptations for residents who are blind or have low vision, such as contrasting color walls and carpeting, large-button telephones, or oversized clocks?	O	O	O
F5. **EXCLUDING A DEMENTIA CARE NEIGHBORHOOD**, does your community have some physical design features for persons with dementia, such as short corridors, contrasting colors, or environmental cues?	O	O	O

G6. **For each of these, does your community:** • **offer it as part of the basic package (base rate) of services; or** • **offer it for an additional fee (not part of the basic package); or** • **not offer it** ***SELECT ONE ANSWER FOR EACH ROW***	**Offered, basic package**	**Offered, additional fee**	**Not offered**
a. **Complete room furnishings**, including furniture and window covering	O	O	O
b. **Local telephone service** (1) in common areas	O	O	O
(2) in apartments/rooms	O	O	O
c. **Cable or satellite TV** (1) in common areas	O	O	O
(2) in apartments/rooms	O	O	O
d. **Internet access** (1) hard-wired, in common areas	O	O	O
(2) hard-wired, in apartments/rooms	O	O	O
(3) wireless internet (WiFi) throughout the building	O	O	O

The next items are about life safety and accessibility of different safety features.

G7. **Does your community have …** ***SELECT ONE ANSWER FOR EACH ROW***	**No**	**Yes, in some**	**Yes, in all**
a. A sprinkler system in resident rooms and apartments	O	O	O
b. A sprinkler system in common areas	O	O	O
c. A smoke detector in resident rooms and apartments	O	O	O
d. A smoke detector in common areas	O	O	O
e. A carbon monoxide detector in targeted areas	O	O	O
f. An emergency call or personal response system available in resident rooms and apartments	O	O	O

G8. **Does your community have a fire alarm system that is …** ***SELECT ONE ANSWER FOR EACH ROW***	**No**	**Yes, in some areas**	**Yes, in all areas**
a. Tied to the fire department	O	O	O
b. Adapted for people who are deaf or hard of hearing, such as flashing lights	O	O	O
c. Adapted for people who are blind or have low vision, such as auditory alarms	O	O	O

G9. **Who provides the furniture for the resident's apartment?** ***SELECT ONE ANSWER***

- O Residents must bring all of their own furniture (all rooms/apartments are unfurnished)
- O Residents may either bring their own furniture or use furniture provided by the community
- O Residents must use the community furniture but may bring small pieces of furniture such as a chair or dresser
- O Residents must use the community furniture and may not bring any furniture

G10. **Are these areas accessible (meaning able to be entered and used) for residents who use (1) manual walkers or wheelchairs, (2) power wheelchairs or scooters?** ***SELECT ONE ANSWER FOR QUESTION (1) AND ONE ANSWER FOR QUESTION (2) FOR EACH ROW***	**(1) For people who use a manual walker or wheelchair?**			**(2) For people who use a power wheelchair or scooter?**			
	No	**Yes, some areas of the building**	**Yes, all areas in the building**	**No**	**Yes, some areas of the building**	**Yes, all areas in the building**	**Not permitted in the building**
a. Rooms/apartments	O	O	O	O	O	O	O
b. Resident bathrooms	O	O	O	O	O	O	O
c. Common dining rooms	O	O	O	O	O	O	O
d. Other common areas, such as living rooms	O	O	O	O	O	O	O

G11. ***This question applies only to communities that operate a dementia neighborhood -- meaning all or a section of the building is dedicated to serving persons with Alzheimer's Disease and other dementias.***

IF YOUR COMMUNITY DOES NOT HAVE A DEMENTIA NEIGHBORHOOD, CHECK THIS BOX AND GO TO SECTION H: ☐

Regarding your dementia neighborhood, ***SELECT ONE ANSWER FOR EACH ROW***	**Yes**	**No**
a. Is the dementia neighborhood secured by a keypad or other safety locking device that prevents persons at risk of elopement from leaving?	O	O
b. Does the dementia neighborhood have some physical design features for persons with dementia, such as short corridors, contrasting colors, or environmental cues?	O	O
c. Do residents in the dementia neighborhood have: (1) access to a common space dedicated to dining?	O	O
(2) access to one or more common spaces dedicated to activities?	O	O
(3) access to a secure outdoor space for activities?	O	O
(4) access to a designated smoking area?	O	O

H. Closing Questions

H1. **If there is something distinctive about your community or services that would be helpful for consumers to know, please indicate it here:**

_____

_____

_____

_____

H2. **What is/are the position(s) of the person(s) completing this form (such as Administrator, Executive Director, Regional Director)?**

_____

_____

. H3 **What is the date this form was completed?** m | m / d | d / y | y |

Thank you for providing this information!

Please return this completed form in the enclosed postage-paid envelope to:
Abt SRBI Inc.
55 Wheeler Street Cambridge, MA 02138