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

# National Post-Acute and Long-Term Care Study

## 2020 Residential Care Community Questionnaire

Dear Administrator or Executive Director,

The Centers for Disease Control and Prevention conducts the National Post-Acute and Long-Term Care Study (formerly known as the National Study of Long-Term Care Providers or NSLTCP). Please complete this questionnaire about the residential care community at the location listed below.

- **Due to the COVID-19 pandemic, we understand services at this residential care community may be temporarily suspended, reduced, or offered through alternative methods. Although some questions may be difficult to answer at this time, please complete the survey to the best of your ability.**
- If this residential care community is associated with another residential care community or is part of a facility or campus that offers multiple levels of care, please answer only for the residential care community portion operating at the location on the label below.
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to https://www.cdc.gov/nchs/npals/index.htm or call 1-877-256-8171.

Label here

Residential care places are known by different names in different states. We refer to all of these places and others like them as residential care communities. Just a few terms used to refer to these places are assisted living, personal care, and adult care homes, facilities, and communities; adult family and board and care homes; adult foster care; homes for the aged; and housing with services establishments.

**Thank you for taking the time to complete this questionnaire**.

National Center for Health Statistics
Division of Health Care Statistics

# Background Information

**1. Is this residential care community located in the same building as, on the grounds of, or immediately adjacent to each of the following settings?**
**MARK YES OR NO IN EACH ROW**

| | Yes | No |
|---|---|---|
| a. Independent living residences | ☐ | ☐ |
| b. Hospital | ☐ | ☐ |
| c. Nursing home or skilled nursing facility | ☐ | ☐ |
| d. Home health agency | ☐ | ☐ |
| e. Hospice agency | ☐ | ☐ |
| f. Adult day services center | ☐ | ☐ |
| g. A specific unit where subacute or rehabilitation care is provided | ☐ | ☐ |

***If you answered "Yes" to any item in question 1, please answer all questions only for the residential care community portion operating at the location on the cover page of this questionnaire.***

**2. What is the type of ownership of this residential care community? MARK ONLY ONE ANSWER**

- ☐ Private—nonprofit
- ☐ Private—for profit
- ☐ Publicly traded company or limited liability company (LLC)
- ☐ Government—federal, state, county, or local

**3. Is this residential care community currently licensed, registered, certified, or otherwise regulated by the State?**

- ☐ Yes
- ☐ No → *Skip to* ***question 43***

**4. At this residential care community, what is the number of licensed, registered, or certified residential care <u>beds</u>?** *Include both occupied and unoccupied beds. If this residential care community is licensed, registered, or certified by* ***<u>apartment or unit</u>****, please count the number of single resident apartments or units as one bed each, two bedroom apartments or units as two beds each and so forth.*
**If none, enter "0."**

☐ Number of beds

→ *If you answered fewer than 4 beds, skip to* ***question 43***

**5. Is this residential care community permitted, licensed or regulated to only serve adults with an intellectual or developmental disability, severe mental illness, or both?** *Do not include Alzheimer's disease or other dementias.*

**MARK ONLY ONE ANSWER**

- ☐ Yes, **both** intellectual or developmental disability and severe mental illness **only**
- ☐ Yes, **only** intellectual or developmental disability
- ☐ Yes, **only** severe mental illness

→ *Skip to* ***question 43***

- ☐ No, none of the above

**6. Does this residential care community offer at least 2 meals a day to residents?**

- ☐ Yes
- ☐ No → *Skip to* ***question 43***

**7. What is the total number of residents currently living in this residential care community?** *Include residents for whom a bed is being held while in the hospital. If you have respite care residents, please include them.* **If none, enter "0."**

☐ Number of residents

→ *If you answered "0," skip to* ***question 43***

**8. Does this residential care community provide or arrange for any of the following types of staff to be on-site 24 hours a day, 7 days a week to meet any resident needs that may arise?** *On-site means the staff are located in the same building, in an attached building or next door, or on the same campus.*

**MARK A RESPONSE IN EACH ROW**

| | Yes | On an as needed basis or on call | No |
|---|---|---|---|
| a. Personal care aide or staff caregiver | ☐ | ☐ | ☐ |
| b. Registered Nurse | ☐ | ☐ | ☐ |
| (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) | | | |
| c. Director, Assistant Director, Administrator or Operator (if they provide personal care or nursing services to residents) | ☐ | ☐ | ☐ |

→ *If you answered "No" to 8a, 8b, and 8c, skip to* ***question 43***

**9. Does this residential care community offer…**

**MARK YES OR NO IN EACH ROW**

| | Yes | No |
|---|---|---|
| a. help with activities of daily living (ADLs), such as help with bathing, either directly or arranged through an outside vendor? | ☐ | ☐ |
| b. assistance with medications, such as the administration of medications, give reminders, or provide central storage of medications? | ☐ | ☐ |

→ *If you answered "No" to both 9a and 9b, skip to* ***question 43***

**10. Is this residential care community owned by a person, group, or organization that owns or manages two or more residential care communities?** *This may include a corporate chain.*

- ☐ Yes
- ☐ No

**11. Is this residential care community authorized or otherwise set up to participate in Medicaid?**

- ☐ Yes
- ☐ No → *Skip to* ***question 13***

**12. During the last 30 days, for how many of the residents currently living in this residential care community did Medicaid pay for some or all of their services received at this community?** **If none, enter "0."**

☐ Number of residents

**13. Does this residential care community**

**only serve adults with dementia or Alzheimer's disease?**

- ☐ Yes → *Skip to* ***question 17***
- ☐ No

**14. Does this residential care community have a distinct unit, wing, or floor that is designated as a dementia, Alzheimer's, or memory care unit?**

- ☐ Yes
- ☐ No → *skip to* ***question 17***

**15. How many licensed beds are in the dementia, Alzheimer's, or memory care unit, wing, or floor?** *If this residential care community is licensed, registered, or certified by apartments or units, please count the number of single resident apartments or units as one bed each, two bedroom apartments or units as two beds each and so forth.* **If none, enter "0."**

☐ Number of beds

**16. Does this dementia or Alzheimer's Special Care Unit have…** **MARK YES OR NO IN EACH ROW**

| | Yes | No |
|---|---|---|
| a. higher staff-to-resident ratios compared to other units? | ☐ | ☐ |
| b. specially trained staff for residents with dementia or Alzheimer's disease? | ☐ | ☐ |

**17. An Electronic Health Record (EHR) is a computerized version of the resident's health and personal information used in the management of the resident's health care. Other than for accounting or billing purposes, does this residential care community use Electronic Health Records?**

- ☐ Yes
- ☐ No

**18. Does this residential care community's computerized system support electronic health information exchange with each of the following providers?** *Do not include faxing.* **MARK YES OR NO IN EACH ROW**

| | Yes | No |
|---|---|---|
| a. Physician | ☐ | ☐ |
| b. Pharmacy | ☐ | ☐ |
| c. Hospital | ☐ | ☐ |
| d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility | ☐ | ☐ |
| e. Other long-term care provider | ☐ | ☐ |

**19. Does this residential care community typically maintain documentation of residents' advance directives or have documentation that an advance directive exists in resident files?**

- ☐ Yes
- ☐ No → *skip to* ***question 21***

**20. Of the current residents, how many have documentation of an advance directive in their file?** **If none, enter "0."**

☐ Number of residents

**21. Does this residential care community have the following infection control policies and practices? MARK YES OR NO IN EACH ROW**

| | Yes | No |
|---|---|---|
| a. Have a written Emergency Operations Plan that is specific to or includes pandemic response | ☐ | ☐ |
| b. Have a designated staff member or consultant responsible for coordinating the infection control program | ☐ | ☐ |
| c. Offer annual influenza vaccination to residents | ☐ | ☐ |
| d. Offer annual influenza vaccination to all employees or contract staff | ☐ | ☐ |

## Services Offered

**22. Services currently offered by this residential care community can include services offered at this physical location or virtually (online or by telephone). For each service listed below… MARK ALL THAT APPLY IN EACH ROW**

| This residential care community... | Provides the service by paid residential care community employees | Arranges for the service to be provided by outside service providers | Refers residents or family to outside service providers | Temporarily does not provide, arrange, or refer for this service | Does not provide, arrange, or refer for this service |
|---|---|---|---|---|---|
| a. Hospice services | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Social work services—provided by licensed social workers or persons with a bachelor's or master's degree in social work, and may include an array of services such as psychosocial assessment, individual or group counseling, support groups, and referral services | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Mental or behavioral health services—target residents' mental, emotional, psychological, or psychiatric well-being and may include diagnosing, describing, evaluating, and treating mental conditions | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Therapy services—physical, occupational, or speech therapies | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Pharmacy services—including filling of or delivery of prescriptions | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Dietary and nutritional services | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Skilled nursing services—must be performed by an RN, LPN or LVN and are medical in nature | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. Transportation services for medical or dental appointments | ☐ | ☐ | ☐ | ☐ | ☐ |

**23.** *The Long-Term Care Ombudsman Program is an advocacy program that serves people living in long-term care facilities. The program works to resolve resident problems, and provides information to residents, their families and facility staff about resident rights, care and quality of life.* **During the last 12 months, how often did a Long-Term Care Ombudsman Program representative assist or visit this residential care community? MARK ONLY ONE ANSWER**

- ☐ At least once every three months
- ☐ Less than once every three months
- ☐ A representative assisted or visited, but unsure how often
- ☐ A representative did not assist or visit in the last 12 months → *Skip to* ***question***
- ☐ Don't know if a representative assisted or visited in the last 12 months → *Skip to* ***question***

**24. During the last 12 months, what did the representative do for this residential care community?**
**MARK YES OR NO IN EACH ROW**

| | Yes | No |
|---|---|---|
| a. Visited residents in-person | ☐ | ☐ |
| b. Contacted or interacted with residents remotely | ☐ | ☐ |
| c. Responded to resident complaints | ☐ | ☐ |

| | | |
|---|---|---|
| d. Worked with resident or family councils—including attending meetings | ☐ | ☐ |
| e. Responded to staff requests for help with resident issues or resident advocacy | ☐ | ☐ |
| f. Provided information or education to staff on resident issues, such as resident rights, care or services | ☐ | ☐ |
| g. Recommended processes to improve resident rights, care or quality of life | ☐ | ☐ |
| h. Other | ☐ | ☐ |

## Resident Profile

**25. Of the residents currently living in this residential care community, what is the sex breakdown? Enter "0" for any categories with no residents.**

| | Number of Residents |
|---|---|
| a. Male | |
| b. Female | |
| **TOTAL** | |

**NOTE: Total should be the same as the number of residents provided in question 7.**

**26. Of the residents currently living in this residential care community, what is the age breakdown? Enter "0" for any categories with no residents.**

| | Number of Residents |
|---|---|
| a. Under 65 years | |
| b. 65–74 years | |
| c. 75–84 years | |
| d. 85 years or older | |
| **TOTAL** | |

**NOTE: Total should be the same as the number of residents provided in question 7.**

**27. Of the residents currently living in this residential care community, what is the racial-ethnic breakdown?** *Count each resident only once. If a non-Hispanic resident falls under more than one category, please include them in the "Two or more races" category.* **Enter "0" for any categories with no residents.**

| | Number of Residents |
|---|---|
| a. Hispanic or Latino, of any race | |
| b. Two or more races, not Hispanic or Latino | |
| c. American Indian or Alaska Native, not Hispanic or Latino | |
| d. Asian, not Hispanic or Latino | |
| e. Black, not Hispanic or Latino | |
| f. Native Hawaiian or Other Pacific Islander, not Hispanic or Latino | |
| g. White, not Hispanic or Latino | |
| h. Some other category reported in this residential care community's system | |
| i. Not reported (race and ethnicity unknown) | |
| **TOTAL** | |

**NOTE: Total should be the same as the number of residents provided in question 7.**

**28. Of the residents currently living in this residential care community, about how many have been diagnosed with each of the following conditions? Enter "0" for any categories with no residents.**

| | Number of Residents |
|---|---|
| a. Alzheimer disease or other dementias | |
| b. Arthritis | |
| c. Asthma | |
| d. Chronic kidney disease | |
| e. COPD (chronic bronchitis or emphysema) | |
| f. Depression | |
| g. Diabetes | |
| h. Heart disease (for example, congestive heart failure, coronary or ischemic heart disease, heart attack, stroke) | |
| i. High blood pressure or hypertension | |

| | |
|---|---|
| j. Intellectual or developmental disability | |
| k. Osteoporosis | |

**29. For about how many of your current residents do you help store or manage their opioid pain medications?** *Include reminders to take the opioid pain medication or handing the opioid pain medication to the residents to take. Examples include morphine, hydrocodone, oxycodone, codeine, fentanyl, and methadone, and combination opioid pain medications like hydrocodone, oxycodone, and codeine with acetaminophen.* ***If none, enter "0."***

Number of residents

**30. Assistance refers to <u>needing any help or supervision from another person, or use of assistive devices.</u> Of the residents currently living in this residential care community, about how many now need <u>any assistance</u> in each of the following activities? Enter "0" for any categories with no residents.**

| | Number of |
|---|---|
| a. With transferring in and out of a bed or chair | |
| b. With eating, like cutting up food | |
| c. With dressing | |
| d. With bathing or showering | |
| e. With using the bathroom (toileting) | |
| f. With locomotion or walking—this includes using a cane, walker, or wheelchair and/or help from another person | |

**31. As best you know, of the residents currently living in this residential care community, about how many were treated in a hospital emergency department in the last 90 days? If none, enter "0."**

☐ Number of residents

**32. As best you know, of the residents currently living in this residential care community, about how many were discharged from an overnight hospital stay in the last 90 days?** *Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.* **If none, enter "0."**

☐ Number of residents

**33. As best you know, about how many of your current residents had a fall in the last 90 days?** *Include falls that occurred in your residential care community or off-site, whether or not the resident was injured, and whether or not anyone saw the resident fall or caught them. Please just count one fall per resident who fell, even if the resident fell more than one time. If one of your residents fell during the last 90 days, but is currently in the hospital or rehabilitation facility, please include that person in your count.* **If no residents had a fall, enter "0."**

Number of residents

## Staff Profile

**34. An individual is considered an employee if the residential care community is required to issue a Form W-2 federal tax form on their behalf. For each staff type below, indicate how many full-time employees and part-time employees this community currently has.** *Include employees who work at this physical location or virtually (on-line or by telephone).* **Enter "0" for any categories with no employees.**

| | Number of Full-Time Employees | Number of Part-Time Employees |
|---|---|---|
| a. Registered nurses (RNs) | | |
| b. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs) | | |
| c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides | | |
| d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work | | |
| e. Activities directors or activities staff | | |

**35. Contract or agency staff refer to individuals or organization staff under contract with and working at this residential care community but are not directly employed by the community. Does this community have any nursing, aide, social work, or activities contract or agency staff?** *Include contract staff who work at this physical location or virtually (on-line or by telephone).*

- ☐ Yes
- ☐ No → *Skip to* ***question 37***

→

**36. For each staff type below, indicate how many full-time contract or agency staff and part-time contract or agency staff this residential care community currently has.** *Do not include individuals directly employed by this residential care community.* **Enter "0" for any categories with no contract or agency staff.**

| | Number of Full-Time Contract or Agency Staff | Number of Part-Time Contract or Agency Staff |
|---|---|---|
| a. Registered nurses (RNs) | | |
| b. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs) | | |
| c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides | | |
| d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work | | |
| e. Activities directors or activities staff | | |

## Information on COVID-19

**37. Since January 2020, how many coronavirus disease (COVID-19) cases did this residential care community have among residents and among employees or contract staff?** *Include only presumptive positive and confirmed cases.* **Enter "0" if none or select don't know if you do not know the number.**

| | COVID-19 cases | | COVID-19 cases that resulted in a hospitalization | | COVID-19 cases that resulted in death | |
|---|---|---|---|---|---|---|
| | | | | Don't Know | | Don't Know |
| a. Residents | | If 1 or more → | | ☐ | | ☐ |
| b. Employees or contract staff | | If 1 or more → | | ☐ | | ☐ |

**38. Since January 2020, how many residents with presumptive positive or confirmed COVID-19 infection did this residential care community need to transfer to another residential care community? If none, enter "0".**

☐ Number of residents

**39. Since January 2020, did this residential care community experience any of the following in your prevention, response, or management of COVID-19 infections? MARK YES, NO, OR DON'T KNOW IN EACH ROW**

| | Yes | No | Don' |
|---|---|---|---|

| | | | t Know |
|---|---|---|---|
| a. Screening of residents daily for fever or respiratory symptoms | ☐ | ☐ | ☐ |
| b. Notifying all residents or families of a case in the residential care community within 24 hours | ☐ | ☐ | ☐ |
| c. Use of telephonics or audio-only calls to assess, diagnose, monitor, or treat residents with presumptive positive or confirmed COVID-19 infection | ☐ | ☐ | ☐ |
| d. Use of telemedicine or telehealth (i.e., audio with video, web videoconference) to assess, diagnose, monitor, or treat residents with presumptive positive or confirmed COVID-19 infection | ☐ | ☐ | ☐ |
| e. Limiting of communal dining and recreational activities in common areas | ☐ | ☐ | ☐ |

**40. Since January 2020 to now, did this residential care community experience a shortage of the following personal protective equipment? MARK YES, NO, OR DON'T KNOW FOR EACH TIME PERIOD**

| | January 2020 to March 2020 | | | April 2020 to June 2020 | | | July 2020 to September 2020 | | | October 2020 to now | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Don't know | Yes | No | Don't know | Yes | No | Don't know | Yes | No | Don't know |
| a. Eye protection, gloves, face masks, or isolation gowns | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. N95 respirators | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**41. Since January 2020, how many residents with presumptive positive COVID-19 infection was this residential care community <u>not</u> able to test due to shortages of test kits? If none, enter "0".**

☐ Number of residents

**42. Since January 2020, did this residential care community impose restrictions on the following individuals from entering the building? MARK NEVER, SOMETIMES, OFTEN, ALWAYS, OR DON'T KNOW IN EACH ROW**

| | Never | Sometimes | Often | Always | Don't know |
|---|---|---|---|---|---|
| a. Family and relatives | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Visitors | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Volunteers | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Non-essential consultant personnel (e.g., barbers, delivery personnel) | ☐ | ☐ | ☐ | ☐ | ☐ |

## Contact Information

**43. We would like to keep your name, telephone number, work e-mail address, and job title for possible future contact related to participation in current and future National Post-Acute and Long-Term Care Study (NPALS) waves. Your contact information will be kept confidential and will not be shared with anyone outside this project team.**

**PLEASE PRINT**

| Your name | First Name | | Last Name | |
|---|---|---|---|---|

| | |
|---|---|
| Your work telephone number, with extension | ☐☐☐ – ☐☐☐ – ☐☐☐☐ **Ext.** ☐☐☐☐ |
| Your work e-mail address | |
| Your job title | |

**Please return your questionnaire in the enclosed return envelope or mail it to:**

NPALS
RTI International
ATTN: Data Capture
5265 Capital Boulevard
Raleigh, NC 27690

**Thank you for participating in the 2020 National Post-Acute and Long-Term Care Study.**