Form Approved
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National Study of Long-Term Care Providers

2014 Residential Care Community Questionnaire

Dear Administrator or Executive Director,

The Centers for Disease Control and Prevention conducts the National Study of Long-Term Care Providers. Please complete this questionnaire about the residential care community at the location listed below.

- **If this residential care community is part of a multi-facility campus or has more than one residential care license, answer only for the place listed below.**
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to http://www.cdc.gov/nchs/nsltcp.htm or call 1-877-225-4434.

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

1 Background Information

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

☐ Yes

☐ No

If you answered No, skip to question 30 on page 8.

2. At this residential care community, what is the number of licensed, registered, or certified residential care **beds**? Include both occupied and unoccupied beds.

If this residential care community is licensed, registered, or certified by **apartment or unit**, 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 30 on page 8.

3. Does this residential care community **only** serve adults with…

MARK YES OR NO IN EACH ROW

	Yes	No
a. an intellectual or developmental disability?	☐	☐
b. severe mental illness? **Do not include Alzheimer's disease or other dementias.**	☐	☐

If you answered Yes to either 3a or 3b, skip to question 30 on page 8.

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

☐ Yes

☐ No

If you answered No, skip to question 30 on page 8.

5. What is the total number of residents currently living in this residential care community? If you have respite care residents, please include them. **If none, enter "0."**

☐ Number of residents

If you answered "0," skip to question 30 on page 8.

6. 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	No
a. Personal care aide or staff caregiver	☐	☐	☐
b. Registered Nurse (RN) or Licensed Practical Nurse (LPN)	☐	☐	☐
c. Director, Assistant Director, Administrator or Operator (if they provide personal care or nursing services to residents)	☐	☐	☐

If you answered No to 6a, 6b, and 6c, skip to question 30 on page 8.

7. 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 7a and 7b, skip to question 30 on page 8.

8. 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

9. 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

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

- ☐ Yes
- ☐ No

If you answered No, skip to question 11.

10a. 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

11. What is the total number of years this residential care community has been operating as a residential care community at this location?

MARK ONLY ONE ANSWER

- ☐ Less than 1 year
- ☐ 1 to 4 years
- ☐ 5 to 9 years
- ☐ 10 to 19 years
- ☐ 20 or more years

12. As a part of the admission process, does this residential care community . . .

MARK YES OR NO IN EACH ROW

	Yes	No
a. screen residents for depression with a standardized tool or scale?	☐	☐
b. accept results from depression screenings performed by other health care providers?	☐	☐

13. Does this residential care community only serve adults with dementia or Alzheimer's disease?

- ☐ Yes
- ☐ No

If you answered Yes, skip to question 14.

13a. Does this residential care community have a distinct unit, wing, or floor that is designated as a dementia or Alzheimer's Special Care Unit?

- ☐ Yes
- ☐ No

If you answered No, skip to question 14.

13b. How many licensed beds are in the dementia or Alzheimer's Special Care Unit? 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

14. Disease-specific programs may include one or more of the following services—education, physical activity, diet/nutrition, medication management, or weight management. Does this residential care community offer **any disease-specific programs** for residents with the following conditions?

MARK YES OR NO IN EACH ROW

	Yes	No
a. Alzheimer's disease and other dementias	☐	☐
b. Cardiovascular disease (e.g., heart disease, stroke, high blood pressure)	☐	☐
c. Depression	☐	☐
d. Diabetes	☐	☐

2 Services Offered

15. For each row, mark if this residential care community provides the service by . . .

- Paid residential care community employees
- Arranging for and paying outside vendors
- Arranging for outside vendors paid by others
- Referral
- **NONE OF THESE APPLY / NOT PROVIDED**

Type of Service	This residential care community provides the service by . . . (MARK ALL THAT APPLY)				NONE OF THESE APPLY/ NOT PROVIDED
	Paid residential care community employees	Arranging for and paying outside vendors	Arranging for outside vendors paid by others	Referral	
a. Routine and emergency dental services by a licensed dentist	☐	☐	☐	☐	☐
b. Hospice services	☐	☐	☐	☐	☐
c. Social work services—provided by licensed social workers or persons with a bachelor's or master's degree in social work, and include an array of services such as psychosocial assessment, individual or group counseling, and referral services	☐	☐	☐	☐	☐
d. Mental health services—target residents' mental, emotional, psychological, or psychiatric well-being and include diagnosing, describing, evaluating, and treating mental conditions	☐	☐	☐	☐	☐
e. Any therapeutic services—physical, occupational, or speech	☐	☐	☐	☐	☐
f. Pharmacy services—including filling of and delivery of prescriptions	☐	☐	☐	☐	☐
g. Podiatry services	☐	☐	☐	☐	☐
h. Skilled nursing services—must be performed by an RN or LPN and are medical in nature	☐	☐	☐	☐	☐
i. Transportation services for medical or dental appointments	☐	☐	☐	☐	☐
j. Transportation services for social and recreational activities, or shopping	☐	☐	☐	☐	☐

3 Staff Profile

16a. What is the **maximum** number of hours per week that **part-time staff** can work at this residential care community?

☐ Hours per week

16b. What is the **minimum** number of hours per week that **full-time staff** can work at this residential care community?

☐ Hours per week

17. **For <u>each</u> category of staff listed below**, please indicate the number of staff that currently work at this residential care community full-time and part-time. Please include:

- both full-time and part-time **residential care community employees** (an individual is considered a community employee if the community is required to issue a Form W-2 on their behalf), and
- other individuals or organization **staff under contract** with and working at this residential care community full-time and part-time.

Enter "0" for any categories with no employees or staff.

Current Residential Care Community Staff		Number of Full-Time Staff If none, enter "0"	Number of Part-Time Staff If none, enter "0"
a. Registered nurses (RNs)	a. Residential care community employee(s)		
	b. Contract staff		
b. Licensed practical nurses (LPNs)/ Licensed vocational nurses (LVNs)	a. Residential care community employee(s)		
	b. Contract staff		
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides	a. Residential care community employee(s)		
	b. Contract staff		
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work	a. Residential care community employee(s)		
	b. Contract staff		
e. Activities directors or activities staff	a. Residential care community employee(s)		
	b. Contract staff		

4 Resident Profile

18. Of the residents currently living in this residential care community, how many are in each of the following categories? Count each resident only once. **Enter "0" for any categories with no residents.**

	NUMBER OF RESIDENTS
a. Hispanic or Latino, of any race	
b. American Indian or Alaska Native, not Hispanic or Latino	
c. Asian, not Hispanic or Latino	
d. Black, not Hispanic or Latino	
e. Native Hawaiian or Other Pacific Islander, not Hispanic or Latino	
f. White, not Hispanic or Latino	
g. Two or more races, 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 provided in question 5.

19. Of the residents currently living in this residential care community, how many are in each of the following categories? **Enter "0" for any categories with no residents.**

	NUMBER OF RESIDENTS
a. Male	
b. Female	
TOTAL	

NOTE: Total should be the same as provided in question 5.

20. Of the residents currently living in this residential care community, how many are in each of the following age categories? **Enter "0" for any categories with no residents.**

	NUMBER OF RESIDENTS
a. 17 years or younger	
b. 18–44 years	
c. 45–54 years	
d. 55–64 years	
e. 65–74 years	
f. 75–84 years	
g. 85 years or older	
TOTAL	

NOTE: Total should be the same as provided in question 5.

21. 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's disease or other dementias	
b. Intellectual/ developmental disability	
c. Severe mental illness	
d. Depression	
e. Cardiovascular disease (e.g., heart disease, stroke, high blood pressure)	
f. Diabetes	

22. Assistance refers to **needing any help or supervision from another person, or use of special equipment**.

Of the residents currently living in this residential care community, about how many now need **any assistance** in each of the following activities? **Enter "0" for any categories with no residents.**

	NUMBER OF RESIDENTS
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. In using the bathroom (toileting)	
f. With locomotion or walking	

23. 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

24. 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

25. Of the residents currently living in this residential care community, about how many had any falls in the last 90 days? Include on-site and off-site falls. **If none, enter "0."**

☐ Number of residents

26. For about how many of the current residents does this residential care community provide medication-related services, such as storing medications; administering medications; or providing assistance to residents with self-administration of medications? **If none, enter "0."**

☐ Number of residents

27. Of residents who moved out in the last 12 months, did **any** leave because the cost of care, including housing, meals, and services required to meet their needs, exceeded their ability to pay?

☐ Yes
☐ No

5 Record keeping

28. An Electronic Health Record 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

29. 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	☐	☐

6 Contact Information

30. In case we need to reach you, please provide your name, telephone number, work e-mail address, and job title. Your contact information will be kept confidential and will not be shared with anyone outside the project team.

PLEASE PRINT

Your full name:

Your work telephone number, with extension:

( )

Your work e-mail address:

Your job title:

Thank you for participating.

Please return this questionnaire in the enclosed return envelope.