**2018 National Study of Long-Term Care Providers**
**RCC Services User Questionnaire**

What is [SAMPLED PERSON'S INITIALS]'s gender?

1 MALE
2 FEMALE

What is [SAMPLED PERSON'S INITIALS]'s age in years?

Is [SAMPLED PERSON'S INITIALS] of Hispanic, Latino, or Spanish origin or descent?

1 YES
2 NO
3 DON't KNOW

Please look at the show card titled "Race" to answer this question. Which one or more of the following would you say is [SAMPLED PERSON'S INITIALS]'s race? Please tell me the numbers that apply from the show card. Any others? SELECT ALL THAT APPLY

1. AMERICAN INDIAN OR ALASKA NATIVE
2. ASIAN
3. BLACK
4. NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
5. WHITE

When did [SAMPLED PERSON'S INITIALS] first move into this residential care community? Please give your best estimate.

MONTH and YEAR
Do not know exact date

Please look at the show card titled "Moved into Community" to answer this question. Approximately how long? Please tell me the number that applies from the show card.

1. 0 TO 3 MONTHS
2. MORE THAN 3 MONTHS TO 6 MONTHS
3. MORE THAN 6 MONTHS TO 1 YEAR
4. MORE THAN 1 YEAR TO 3 YEARS
5. MORE THAN 3 YEARS TO 5 YEARS
6. MORE THAN 5 YEARS

Please look at the show card titled “Live Before” to answer this question. Where did [SAMPLED PERSON'S INITIALS] live immediately before moving to this residential care community? Please tell me the number that applies from the show card.

1. PRIVATE RESIDENCE (HOUSE, APARTMENT, ROOM)
2. RETIREMENT OR INDEPENDENT LIVING COMMUNITY
3. DIFFERENT ASSISTED LIVING OR RESIDENTIAL CARE COMMUNITY OR GROUP HOME
4. ACUTE CARE HOSPITAL
5. LONG-TERM CARE HOSPITAL OR INPATIENT REHABILITATION FACILITY
6. SKILLED NURSING FACILITY (SNF) FOR SHORT-TERM REHABILITATION (≤ 100 DAYS)
7. NURSING HOME OR OTHER INSTITUTIONAL SETTING (> 100 DAYS)
8. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES
9. PSYCHIATRIC FACILITY
10. HOMELESS
11. JAIL
12. OTHER

At this residential care community, does [SAMPLED PERSON'S INITIALS] currently share “his”/ “her” room or apartment with another person?

1 YES
2 NO

Is this person [SAMPLED PERSON'S INITIALS]'s partner, spouse, or other relative?

1 YES
2 NO

Does [SAMPLED PERSON'S INITIALS] live in a distinct unit, wing, or floor that is designated as an Alzheimer's Disease, dementia, or memory care unit at this residential care community?

1 YES
2 NO

During the last complete month, what was the total monthly charge for [SAMPLED PERSON'S INITIALS] to live in this residential care community? Include the basic monthly charge and charges for any additional services.

RECORD DOLLAR AMOUNT WITHOUT CENTS

During the last complete month, did Medicaid pay for any of the services that [SAMPLED PERSON'S INITIALS] received at this residential care community? Please include any funding from a Medicaid state plan, Medicaid waiver, Medicaid managed care.

1 YES
2 NO
3 DON’T KNOW

Please look at the show card titled “Conditions” to answer this question. As far as you know, has a doctor or other health professional ever diagnosed [SAMPLED PERSON'S INITIALS] with any of the following conditions? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ALCOHOL ABUSE
2. ALZHEIMER’S DISEASE OR OTHER DEMENTIA
3. ANEMIA
4. ANXIETY DISORDER
5. ARTHRITIS OR RHEUMATOID ARTHRITIS
6. ASTHMA
7. CANCER OR MALIGNANT NEOPLASM OF ANY KIND
8. CEREBRAL PALSY
9. CONGESTIVE HEART FAILURE
10. COPD (CHRONIC BRONCHITIS OR EMPHYSEMA)
11. DEPRESSION
12. DIABETES
13. EPILEPSY
14. GLAUCOMA
15. GOUT, LUPUS, OR FIBROMYALGIA
16. HEART ATTACK (MYOCARDIAL INFARCTION)
17. HEART DISEASE (CORONARY OR ISCHEMIC)
18. HIGH BLOOD PRESSURE OR HYPERTENSION
19. HUMAN IMMUNODEFICIENCY VIRUS (HIV)/AIDS
20. HUNTINGTON'S DISEASE
21. INTELLECTUAL OR DEVELOPMENTAL DISABILITIES
22. KIDNEY DISEASE
23. MACULAR DEGENERATION
24. MUSCULAR DYSTROPHY
25. MULTIPLE SCLEROSIS
26. OBESITY
27. OSTEOPOROSIS
28. PARKINSON’S DISEASE
29. PARTIAL OR TOTAL PARALYSIS
30. PRESSURE WOUND/INJURY
31. SEVERE MENTAL ILLNESS SUCH AS SCHIZOPHRENIA OR PSYCHOSIS OR BIPOLAR DISORDER (EXCLUDES DEPRESSION OR ANXIETY DISORDER)
32. SPINAL CORD INJURY
33. STROKE
34. TRAUMATIC BRAIN INJURY
35. NONE OF THESE

The next question asks about prescription medications [SAMPLED PERSON'S INITIALS] may take. Include standing and PRN or as needed medications, but exclude over-the-counter medications or supplements, unless they have been prescribed by a health care provider. About how many prescription medications does [SAMPLED PERSON'S INITIALS] currently take on a typical day? Would you say…

1 0
2 1-2
3 3-4
4 5-6
5 7-8
6 9-10, or
7 more than 10

Please look at the show card titled "Antipsychotic Medications" to answer this question. The following is a list of the generic and brand names of antipsychotic medications. In the last seven days, which, if any, of these medications did [SAMPLED PERSON'S INITIALS] receive, either on an as needed basis or on a routine basis? Please tell me the numbers that apply from the show card. Any others?

1. ABILIFY (ARIPIPRAZOLE)
2. CLOZARIL OR FAZACLO (CLOZAPINE)
3. FANAPT (ILOPERIDON)
4. GEODON (ZIPRASIDONE)
5. HALDOL (HALOPERIDOL)
6. INVEGA (PALIPERIDONE)
7. LOXITANE (LOXAPINE)
8. NAVANE (THIOTHIXENE)
9. ORAP (PIMOZIDE)
10. RISPERDAL (RISPERIDONE)
11. SAPHRIS (ASENAPINE)
12. SEROQUEL (QUETIAPINE)
13. ZYPREXA (OLANZAPINE)
14. NONE OF THE ABOVE

The next questions ask about difficulties (SAMPLED PERSON'S INITIALS) may have doing certain activities because of a health problem. How much difficulty does (SAMPLED PERSON'S INITIALS) have remembering or concentrating? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

1 NO DIFFICULTY
2 SOME DIFFICULTY
3 A LOT OF DIFFICULTY
4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have seeing, even if wearing glasses? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

1 NO DIFFICULTY
2 SOME DIFFICULTY
3 A LOT OF DIFFICULTY
4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have hearing, even if using a hearing aid? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

1 NO DIFFICULTY
2 SOME DIFFICULTY
3 A LOT OF DIFFICULTY
4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have walking or climbing steps? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

1 NO DIFFICULTY
2 SOME DIFFICULTY
3 A LOT OF DIFFICULTY
4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have self-care such as washing all over or dressing? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

1 NO DIFFICULTY
2 SOME DIFFICULTY
3 A LOT OF DIFFICULTY
4 CANNOT DO AT ALL

Using “his”/“her” usual customary language, how much difficulty does (SAMPLED PERSON'S INITIALS) have communicating, for example understanding or being understood? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

1 NO DIFFICULTY
2 SOME DIFFICULTY
3 A LOT OF DIFFICULTY
4 CANNOT DO AT ALL

The next questions ask about assistance [SAMPLED PERSON'S INITIALS] may need to perform certain activities.

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to transfer in and out of a bed or chair? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
2 USE OF AN ASSISTIVE DEVICE
3 BOTH
4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to eat, like cutting up food? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
2 USE OF AN ASSISTIVE DEVICE
3 BOTH
4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to dress? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
2 USE OF AN ASSISTIVE DEVICE
3 BOTH
4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to bathe or shower? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
2 USE OF AN ASSISTIVE DEVICE
3 BOTH
4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to use the bathroom or toileting? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
2 USE OF AN ASSISTIVE DEVICE
3 BOTH
4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need for locomotion or to walk? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
2 USE OF AN ASSISTIVE DEVICE
3 BOTH
4 NEED NO ASSISTANCE

Please look at the show card titled “Incontinence” to answer this question. As far as you know, has [SAMPLED PERSON'S INITIALS] had any episode of incontinence during the last seven days? Please tell me the number that applies from the show card.

1. YES, BOWEL ONLY
2. YES, URINARY ONLY
3. YES, BOTH BOWEL AND URINARY
4. NO, NEITHER
5. NOT APPLICABLE (COLOSTOMY, ILEOSTOMY)
6. NOT APPLICABLE (INDWELLING CATHETER, UROSTOMY)

During the past 12 months, was [SAMPLED PERSON'S INITIALS] treated in a hospital emergency department?

1 YES
2 NO
3 DON'T KNOW

During the past 90 days, was [SAMPLED PERSON'S INITIALS] treated in a hospital emergency department?

1 YES
2 NO
3 DON'T KNOW

During the past 12 months, was [SAMPLED PERSON'S INITIALS] discharged from an overnight hospital stay? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.

1 YES
2 NO
3 DON'T KNOW

Was [SAMPLED PERSON'S INITIALS] discharged from an overnight hospital stay during the past 90 days? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.

1 YES
2 NO
3 DON'T KNOW

Please look at the show card titled "Hospitalization" to answer this question.

What was the one primary reason for [SAMPLED PERSON'S INITIALS]'s hospitalization? If "he"/"she" had more than one hospital discharge in the past 90 days, answer for the most recent hospital discharge.

1. ASTHMA
2. BRONCHITIS
3. C. DIFFICILE INFECTION
4. CHRONIC OBSTRUCTIVE PULMONARY DISEASE *(COPD)*
5. CONGESTIVE HEART FAILURE *(CHF)*
6. CONSTIPATION/INTESTINAL IMPACTION
7. DEHYDRATION
8. DIABETES—SHORT-TERM COMPLICATION
9. DISEASES OF THE SKIN
10. FALLS OR TRAUMA
11. HYPERTENSION OR HYPOTENSION
12. MENTAL STATUS CHANGES
13. PNEUMONIA
14. PRESSURE INJURY/ULCER
15. URINARY TRACT OR KIDNEY INFECTION
16. NONE OF THE ABOVE

Was [SAMPLED PERSON'S INITIALS] re-admitted to the hospital for an overnight stay within 30 days of this hospital discharge? Include outpatient observation and inpatient admission.

1 YES
2 NO
3 DON'T KNOW

The next section asks whether [SAMPLED PERSON'S INITIALS] has had any falls. By falls we mean any fall, slip, or trip in which [SAMPLED PERSON'S INITIALS] lost “his”/“her” balance and landed on the floor or ground or at a lower level. Please include falls that occurred at your residential care community or off-site, whether or not [SAMPLED PERSON'S INITIALS] was injured, and whether or not anyone saw [SAMPLED PERSON'S INITIALS] fall or caught them. As best you know, during the past 90 days, how many falls has [SAMPLED PERSON'S INITIALS] had?

Number of falls _____

As best you know, did the fall/any of these falls that [SAMPLED PERSON'S INITIALS] had during the past 90 days occur at the residential care community?

1 YES
2 NO
3 DON'T KNOW

Please look at the show card titled “Fall Injury” to answer this question. Did [SAMPLED PERSON'S INITIALS]'s fall/any of these falls [SAMPLED PERSON'S INITIALS] had result in a minor injury, a major injury, or no injury? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY

1. MINOR INJURY - ABRASION, CUT, HEMATOMA, LACERATION, SCRATCH, SKIN TEAR, SPRAIN, SUPERFICIAL BRUISE
2. MAJOR INJURY - BONE FRACTURE, BROKEN BONE, CLOSED HEAD INJURY WITH ALTERED CONSCIOUSNESS, JOINT DISLOCATION, SUBDURAL HEMATOMA
3. NO INJURY

Please look at the show card titled "Services" to answer this question. The following services may be offered by residential care community staff or provided at the community by non-community staff. Which of these services does [SAMPLED PERSON'S INITIALS] currently use? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ASSISTANCE FROM A PERSON WITH AT LEAST ONE ACTIVITY OF DAILY LIVING *(BATHING, DRESSING, EATING, TOILETING, TRANSFERRING)*
2. BEHAVIORAL OR MENTAL HEALTH—TARGET RESIDENTS' MENTAL, EMOTIONAL, PSYCHOLOGICAL, OR PSYCHIATRIC WELL-BEING, AND MAY INCLUDE DIAGNOSING, DESCRIBING, EVALUATING, AND TREATING MENTAL CONDITIONS
3. CONTINENCE MANAGEMENT *(E.G., ABSORBENT PADS, BLADDER OR BOWEL RETRAINING, CATHETER, MEDICATION, TOILETING REGIME)*
4. DENTAL *(ROUTINE OR EMERGENCY BY LICENSED DENTIST)*
5. DIETARY OR NUTRITIONAL
6. HOSPICE
7. MANAGE, SUPERVISE, OR STORE MEDICATIONS; ADMINISTER MEDICATIONS; OR PROVIDE ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATIONS
8. OCCUPATIONAL THERAPY
9. PAIN MANAGEMENT *(MEDICATION OR NON-PHARMACOLOGICAL APPROACHES)*
10. PALLIATIVE CARE *(RELIEF FROM SYMPTOMS, PAIN, AND STRESS OF SERIOUS ILLNESS, REGARDLESS OF DIAGNOSIS)*
11. PHARMACY--INCLUDING FILLING OF OR DELIVERY OF PRESCRIPTIONS
12. PHYSICAL THERAPY
13. PODIATRY
14. SKILLED NURSING--MUST BE PERFORMED BY AN RN OR LPN/LVN AND ARE MEDICAL IN NATURE
15. SKIN WOUND/INJURY CARE
16. SOCIAL WORK—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, AND REFERRAL SERVICES
17. SPEECH THERAPY
18. TRANSPORTATION FOR MEDICAL OR DENTAL APPOINTMENTS
19. TRANSPORTATION FOR SOCIAL AND RECREATIONAL ACTIVITIES OR SHOPPING
20. NONE OF THE ABOVE

Please look at the show card titled "Documentation" to answer this question. For which of the following items does this residential care community have documentation in [SAMPLED PERSON'S INITIALS]'s file? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ADVANCE DIRECTIVE
2. HEALTH CARE PROXY OR DURABLE MEDICAL POWER OF ATTORNEY
3. PHYSICIAN DOCUMENTATION OF CONDITION THAT MAY RESULT IN LIFE EXPECTANCY LESS THAN 6 MONTHS
4. PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT *(POLST)*
5. NONE OF THESE

Please look at the show card titled “Verbal or Behavioral Symptoms” to answer this question. As far as you know, at any time in the last seven days [SAMPLED PERSON'S INITIALS] exhibited any verbal or physical behavioral symptoms directed toward others, for example threatening, screaming, cursing, hitting, kicking, pushing, scratching, grabbing, or abusing others sexually? Please tell me the number that applies from the show card.

1. YES, VERBAL ONLY
2. YES, PHYSICAL ONLY
3. YES, BOTH VERBAL AND PHYSICAL
4. NO, NEITHER