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FORM **NNHS-1**
(3-19-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

FACILITY QUESTIONNAIRE

1997 NATIONAL NURSING HOME SURVEY

Section A – FACILITY INFORMATION

1a. Facility telephone number	**b.** Alternate telephone number	**c.** Alternate telephone number

2a. Administrator name	**b.** Respondent name

Section B – RECORD OF CONTACTS

Day (a)	Date (b)	Time (c)	Notes (d)
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	

Section C – RECORD OF INTERVIEW

1. STATUS OF INTERVIEW – *Mark (X) appropriate box.*

01 ☐ Complete interview
02 ☐ Partial interview
03 ☐ Refusal
04 ☐ Unable to locate
05 ☐ Not a nursing home
06 ☐ Temporarily closed
07 ☐ Not yet in operation
08 ☐ No longer operating
09 ☐ Merged with (Control No.) _____
10 ☐ Duplicate (Control No. of duplicate) _____
11 ☐ Other noninterview – *Specify* _____

2. Date of interview Month | Day | Year	**3.** Field Representative name	FR Code

Notes	Facility FAX number

Section D – ARRANGING THE ADMINISTRATOR APPOINTMENT

1. INTRODUCTION

Good morning (afternoon). My name is *(Name)*. **I'm from the Bureau of the Census. We are currently conducting the National Nursing Home Survey for the National Center for Health Statistics of the Centers for Disease Control and Prevention. We are studying nursing homes and their patients. You should have received a letter from Edward J. Sondik, the Director of the National Center for Health Statistics, which describes this project. Have you received this letter?**

☐ Yes – *Skip to Item 3 , NAME VERIFICATION.*
☐ No – *Continue with Item 2, SURVEY EXPLANATION.*

2. SURVEY EXPLANATION

If administrator wants a copy of the letter, explain that you will bring a copy when you visit the facility.

I'm sorry that you did not receive the letter. Let me briefly outline its contents.

The National Nursing Home Survey is authorized under Section 306 of the Public Health Service Act to collect baseline information about nursing care facilities, their services, and patients. The statistics compiled from the data are used to support research for effective treatment of long-term health problems and to study utilization of nursing facilities and the efficient use of the Nation's health care resources.

All information which would permit identification of the individual or individual facility will be held in strict confidence, will be used ONLY by persons involved in the survey, and will not be disclosed or released to others for any purpose.

The survey includes a small sample of nursing homes. Although your participation is voluntary and there are no penalties for refusing to answer any questions, it is essential that we obtain data from all sample facilities.

READ IF NECESSARY:

We are asking participants for a list of current residents and a list of discharges during a designated one-month period. We will draw a sample of 6 current residents and a sample of 6 discharges from the lists and complete a questionnaire for each of the 12 sampled residents.

Continue with Item 3, NAME VERIFICATION

3. NAME VERIFICATION

I would like to verify some information from my records. Is *(Name of facility on label)* **the correct name of your facility?**

☐ Yes – *Go to Item 4, ADDRESS VERIFICATION*
☐ No – *Enter correct facility name below.* ↙

4. ADDRESS VERIFICATION

Is *(Address of facility on label)* **the correct address?**

☐ Yes – *Go to Item 5 – SET APPOINTMENT*
☐ No – *Enter correct facility address below.* ↙

Number	Street	P.O. Box, Route, etc.
City or town		
State		ZIP code

5. SET APPOINTMENT

I would like to arrange a morning appointment at your convenience to conduct the survey. What would be a convenient date and time to visit your facility?

Day	Date	Time	a.m. p.m.
Day	Date	Time	a.m. p.m.

6. **Could you give me directions to your facility from some easy to identify starting point?** *(Record directions in number 7 below.)*

Thank you very much for your time. I will see you at *(Time)* **on** *(Date)*. **Good-bye.**

7. DIRECTIONS TO FACILITY

Section E – QUESTIONS ABOUT THE FACILITY

Before I begin the interview, I'd like to take a moment to explain the purpose of the survey. I believe you (received/did not receive) the letter from the National Center for Health Statistics.

If administrator did not receive the letter, hand him/her a copy. Allow him/her to briefly read it through.

As it says in the letter, the purpose of this survey is to collect baseline information about nursing homes such as yours. The information you provide is strictly confidential and will be used only by persons involved in the survey and only for the purposes of the survey.

1. Are any personal care or nursing care services routinely provided to residents in addition to room and board?

01 ☐ Yes – *GO to item 2a*
02 ☐ No – *THIS FACILITY IS OUT-OF-SCOPE FOR THE SURVEY. PLEASE TERMINATE THE INTERVIEW BY SAYING TO THE RESPONDENT:*

It would appear that your facility was incorrectly selected for inclusion in this survey. At this time, I will terminate this interview. I will report the situation to my immediate supervisor who will call you in a few days to verify this information.

Section E – QUESTIONS ABOUT THE FACILITY – Continued

HAND FLASHCARD 1

2a. What is the type of ownership of this facility as shown on this card?

Mark (X) only ONE box.

01 ☐ PROPRIETARY – *Includes individually or privately owned, partnership, corporation*

02 ☐ NONPROFIT – *Includes church-related, nonprofit corporation, other nonprofit ownership*

03 ☐ STATE OR LOCAL GOVERNMENT – *Includes State, county, city, city-county, hospital district or authority*

04 ☐ FEDERAL GOVERNMENT – *Includes USPHS, Armed Forces, Veterans Administration* ***OR*** *other Federal Government – Specify if other than listed here* ↙

_____

05 ☐ OTHER – *Specify* ↙

_____

b. Is this facility a member of a chain or group?

01 ☐ Yes
02 ☐ No

3. How many beds are currently available for residents? Include all beds set up and staffed for use whether or not they are in use by residents at the present time. Do not include beds used by staff or owners, or beds used exclusively for emergency purposes, solely day care, or solely night care.

_____ Total available beds

4. What is the total number of residents on the rolls of this facility as of midnight last night?

_____ Number of residents

9999 ☐ Don't know

5. *HAND FLASHCARD 2*

Ask items 5(a) through 5(l) in ***PART I FIRST****. As you ask each item, PAUSE to allow the respondent time to refer to the flashcard. Mark (X) the "Yes/No" box as appropriate for each item. Then,* ***GO TO PART II****, and ask the question for each item marked "Yes" in Part I.*

PART I Does your facility have special, physically distinct or designated clusters of beds, or segregated wings or units, used exclusively for —		PART II How many beds are in these units?
(a) AIDS/HIV care?	01 ☐ Yes 02 ☐ No	**(a)** _____ beds
(b) Alzheimer care?	01 ☐ Yes 02 ☐ No	**(b)** _____ beds
(c) Brain injury care?	01 ☐ Yes 02 ☐ No	**(c)** _____ beds
(d) Children with disabilities?	01 ☐ Yes 02 ☐ No	**(d)** _____ beds
(e) Cognitively impaired residents?	01 ☐ Yes 02 ☐ No	**(e)** _____ beds
(f) Dialysis care?	01 ☐ Yes 02 ☐ No	**(f)** _____ beds
(g) Hospice care?	01 ☐ Yes 02 ☐ No	**(g)** _____ beds
(h) Huntington disease care?	01 ☐ Yes 02 ☐ No	**(h)** _____ beds
(i) Rehabilitation care?	01 ☐ Yes 02 ☐ No	**(i)** _____ beds
(j) Sub-acute care?	01 ☐ Yes 02 ☐ No	**(j)** _____ beds
(k) Ventilatory/pulmonary care?	01 ☐ Yes 02 ☐ No	**(k)** _____ beds
(l) Other special care units? *Specify* ↙ _____	01 ☐ Yes 02 ☐ No	**(l)** _____ beds

6. Is this facility certified by both Medicare and Medicaid, Medicare only, Medicaid only, or neither?

01 ☐ Both Medicare and Medicaid
02 ☐ Medicare only – *SKIP to item 8a*
03 ☐ Medicaid only – *SKIP to item 9a*
04 ☐ Neither – *SKIP to item 10a*

7. How many beds are certified under BOTH Medicare and Medicaid?

_____ Number of beds certified by BOTH Medicare and Medicaid

Section E – QUESTIONS ABOUT THE FACILITY – Continued

8a. How many beds are certified under Medicare?

_____ Medicare beds

b. What is the per diem rate that you receive from Medicare for routine services?

$ _____ per diem

SKIP TO ITEM 10a IF "MEDICARE ONLY" IN ITEM 6.

9a. How many beds are certified under Medicaid?

_____ Medicaid beds

b. What is the per diem rate that you receive from Medicaid for routine services?

$ _____ per diem

10a. Do you have any beds that are not certified by either Medicare or Medicaid?

01 ☐ Yes
02 ☐ No – *SKIP to item 11*

b. How many of these beds does your facility have?

_____ Number of beds not certified by Medicare/Medicaid

11. How many admissions were there to this facility during calendar year 1996?

_____ Admissions in 1996

00 ☐ None

HAND FLASHCARD 3

12. Does this facility offer any of the following services to residents at this facility?

Mark (X) all that apply.

01 ☐ Dental services
02 ☐ Help with oral hygiene
03 ☐ Home health services
04 ☐ Hospice services
05 ☐ Medical services
06 ☐ Mental health services
07 ☐ Nursing services
08 ☐ Nutrition services
09 ☐ Occupational therapy
10 ☐ Personal care
11 ☐ Physical therapy
12 ☐ Podiatry services
13 ☐ Prescribed medicines or nonprescribed medicines
14 ☐ Sheltered employment
15 ☐ Social services
16 ☐ Special education
17 ☐ Speech or hearing therapy
18 ☐ Transportation
19 ☐ Vocational rehabilitation
20 ☐ Equipment or devices
21 ☐ Other – *Specify*

_____

HAND FLASHCARD 4

13. Does this facility provide any of the following services "on-site" or "off-site" to persons who are NOT residents of the facility?

Mark (X) all that apply.

00 ☐ None
01 ☐ Adult day care
02 ☐ Dialysis
03 ☐ Home health services
04 ☐ Home delivered meals
05 ☐ Homemaker or chore services
06 ☐ Infusion therapy
07 ☐ Rehabilitation therapy
08 ☐ Skilled nursing care
09 ☐ Other services to non-residents – *Specify*

_____

14. Does your facility have an organized program to annually offer influenza vaccination to all residents?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

15. What proportion of your residents have been vaccinated against influenza in the past 12 months? Include all vaccinated residents, even if not done at this facility.

_____ %

01 ☐ Don't know

Section E – QUESTIONS ABOUT THE FACILITY – Continued

16. Does your facility have an organized program to offer pneumococcal vaccine, that is pneumonia vaccination, to all residents?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

17. What proportion of your residents have ever been vaccinated against pneumococcal pneumonia? Include all vaccinated residents, even if not done at this facility.

_____ %

01 ☐ Don't know

18a. Does this facility currently have any patients who are in a PROLONGED AND PROFOUND COMA, and are not arousable?

01 ☐ Yes
02 ☐ No – *SKIP to item 19a*

b. How many patients are in a prolonged and profound coma?

_____ Number of patients

19a. Are dentist services available to residents of this facility?

01 ☐ Yes, at this facility
02 ☐ Yes, outside this facility
03 ☐ No, services not available
} *SKIP to item 20a*

HAND FLASHCARD 5

b. What type of dentist services are available in this facility?

Mark (X) ONLY one box.

01 ☐ Dentist(s) on the premises at all times
02 ☐ Dentist(s) on the premises during the daytime hours every weekday, and on-call on weekends and at other times
03 ☐ Dentist(s) on the premises at scheduled times, no less than once per month and on-call remainder of time
04 ☐ Dentist(s) on the premises at scheduled times but less often than once per month and on-call remainder of time
05 ☐ Dentist(s) available on-call only
06 ☐ Other – *Specify* ↙

_____

20a. Are the services of a dental hygienist available to residents in this facility?

01 ☐ Yes, at this facility
02 ☐ Yes, outside this facility
03 ☐ No, services provided by nurse(s) or dentist(s)
04 ☐ No dental hygienist services available
} *SKIP to item 21*

HAND FLASHCARD 6

b. What type of dental hygienist services are available in this facility?

Mark (X) ONLY one box.

01 ☐ Dental hygienist(s) on the premises at all times
02 ☐ Dental hygienist(s) on the premises during the daytime hours every weekday
03 ☐ Dental hygienist(s) on the premises at scheduled times, no less than once per month
04 ☐ Dental hygienist(s) on the premises at scheduled times, but less often than once per month
05 ☐ Dental hygienist(s) available on-call only
06 ☐ Other – *Specify* ↙

_____

Notes

Section E – QUESTIONS ABOUT THE FACILITY – Continued

HAND FLASHCARD 7

21. How many full-time equivalent (FTE) employees work in this facility for each of the following type of employee —

If the respondent cannot provide FTE information, then collect the number of full-time employees and the number of part-time employees for each category.

Make an entry for each type of employee. If the answer is "None," enter "0" in the answer space for the type of employee.

	FTE employees	**OR**	Number of full-time employees	**AND**	Number of part-time employees
(1) Administrator/Assistant Administrator?	_____		_____		_____
(2) Registered Nurses (R.N.)?	_____		_____		_____
(3) Licensed Practical Nurses (LPN) or Licensed Vocational Nurses (L.V.N.)?	_____		_____		_____
(4) Nurses Aides/Orderlies?	_____		_____		_____
(5) Physicians (M.D. or D.O.), Residents and Interns?	_____		_____		_____
(6) Dentists?	_____		_____		_____
(7) Dental Hygienists?	_____		_____		_____
(8) Physical Therapists?	_____		_____		_____
(9) Speech Pathologists and/or Audiologists?	_____		_____		_____
(10) Dieticians or Nutritionists?	_____		_____		_____
(11) Podiatrists?	_____		_____		_____
(12) Social Workers?	_____		_____		_____
(13) All others? – *Specify* _____	_____		_____		_____

HAND FLASHCARD 8

22. Do volunteers, that is persons serving without pay, provide any of the following services?

Mark (X) all that apply.

00 ☐ None
01 ☐ General office help
02 ☐ Reception
03 ☐ Visiting, general aides
04 ☐ Emotional or mental health counseling
05 ☐ Other – *Specify*

_____

23. What is the basic charge for private pay patients at each level of care —

a. Skilled?	$ _____ . ____ per	01 ☐ Day 02 ☐ Month 03 ☐ Not applicable
b. Intermediate?	$ _____ . ____ per	01 ☐ Day 02 ☐ Month 03 ☐ Not applicable
c. Residential?	$ _____ . ____ per	01 ☐ Day 02 ☐ Month 03 ☐ Not applicable
d. Other? – *Specify* _____	$ _____ . ____ per	01 ☐ Day 02 ☐ Month 03 ☐ Not applicable

Notes

Section E – QUESTIONS ABOUT THE FACILITY – Continued

READ **To complete this survey, I will need a list of all current residents, and a list of discharges for the month of** *(Insert discharge sample month and year)*. **From these lists, I will select a sample of no more than 6 current residents and 6 discharges.**

24a. From whom shall I obtain the list of current residents?

Name

Title

b. I will need these residents' medical records and the cooperation of a staff member best acquainted with these residents in order to obtain the information on this questionnaire.

Hand the administrator a copy of the NNHS-3, Current Resident Questionnaire. Allow him/her to examine it briefly. Retrieve the questionnaire and continue reading.

I will not be contacting or interviewing the residents in any way. I will depend on your staff to consult the medical records.

Would *(Person named in item 24a)* **know which staff member I should interview for those residents selected for the sample?**

01 ☐ Yes – *Go to item 25a*
02 ☐ No – *Determine which staff member would have this knowledge and enter the name and title below.*

Name

Title

25a. From whom shall I obtain the list of discharges?

☐ Same as 24a

Name

Title

b. I will need the help of a staff person familiar with the discharge records to aid me in completing the information requested in this questionnaire.

Hand the administrator a copy of the NNHS-5, Discharged Resident Questionnaire. Allow him/her to examine it briefly. Retrieve the questionnaire and continue reading.

Would *(person named in item 24a)* **know which staff member I should interview for those discharges that fall into the sample?**

01 ☐ Yes – *GO to item 26 below*
02 ☐ No – *Determine which staff member would have this knowledge and enter the name and title below.*

Name

Title

26. Thank you for your time. I will be checking back with you before I leave to say goodbye.

At this time, could you introduce me to *(Names of person(s) listed in items 24a, 24b, 25a and 25b)*.

Notes