2004 NATIONAL NURSING HOME SURVEY FACILITY QUESTIONNAIRE

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2004 NATIONAL NURSING HOME SURVEY FACILITY QUESTIONNAIRE

Facility Qualification (FQ) Module

FQ1.

Before we begin, I need to verify that I'm in the right place and that our information about you is correct.

Is {DspFacName} the exact name of this facility?

YES..	1
NO...	2
DK	
RF	

FQ1A.

What is the correct name of this facility?

VERIFY SPELLING.

FACILITY NAME

FQ1B.

ENTER REASON FOR NAME UPDATE.

IF NEEDED, PROBE FOR REASON.

MINOR CORRECTING OR COMPLETING	1
SIGNIFICANT CORRECTION (MIGHT BE A DIFFERENT NH, MIGHT NO LONGER BE A NH, UNKNOWN).........................	2
FACILITY NAME CHANGED (FROM FORMAL TO COMMON USAGE, NEW OWNER, MORE MARKETABLE, PREFERENCE)...	3

FQ2.

Is your (home/facility)'s address...

{ADDRESS1}
{CITY, STATE ZIP}?

YES..	1
NO...	2
DK	

FQ2A.

What is the correct address of this facility?

ENTER ADDRESS LINE 1. VERIFY SPELLING.

_____

FQ2B.

[What is the correct address of this facility?]

ENTER ADDRESS LINE 2. VERIFY SPELLING.

_____

FQ2C.

[What is the correct address of this facility?]

ENTER CITY. VERIFY SPELLING.

_____

FQ2D.

[What is the correct address of this facility?]

ENTER STATE. VERIFY SPELLING.

_____

FQ2E.

[What is the correct address of this facility?]

ENTER ZIP.

_____

FQ2F.

       ENTER REASON FOR ADDRESS UPDATE.

       IF NEEDED, PROBE FOR REASON.

MINOR CORRECTING OR COMPLETING	1
SIGNIFICANT CORRECTION (NH MOVED, MIGHT NOT BE SAMPLED NH, UNKNOWN)	2
FACILITY ADDRESS CHANGED FOR SOME <u>OTHER</u> REASON (STREET RE-NAMED, ADDRESS RE-ASSIGNED, ENTRANCE RE-LOCATED)	3

FQ4.

       Is the phone number {AREA CODE AND PHONE NUMBER}?

                  YES 1
                  NO 2

FQ4A.

       What is the area code and phone number of this facility?

       |_|_|_|-|_|_|_|-|_|_|_|_|

FQ5.

       Is {FACILITY} part of a chain?

       PRESS F1 FOR HELP SCREEN.

                  YES 1
                  NO 2

FQ7. Is {FACILITY} licensed by the state health department or some other state agency as a nursing home? Please include skilled nursing facilities (SNF).

                  YES 1
                  NO 2

FQ8.   What type of place is {FACILITY}?

PRESS F1 FOR HOSPITAL AND HOSPITAL-BASED SKILLED NURSING FACILITY (SNF) DEFINITIONS.

SHOW CARD FQ1.

CCRC OR
RETIREMENT COMMUNITY 3
NURSING HOME/UNIT WITHIN
  A CCRC OR RETIREMENT
   CENTER 4
HOSPITAL 6
HOSPITAL-BASED SKILLED NURSING
FACILITY (SNF) 7

HOME OFFICE OR MANAGE-
  MENT OFFICE FOR A CHAIN
  OR GROUP OF OFF-SITE
  NURSING FACILITIES 13
OTHER (SPECIFY) 91
DK
RF

FQ8A.

[What type of place is {FACILITY}?]

_____

FQ9.

Does {FACILITY} have any part or unit licensed as a nursing home or a nursing facility by the state health department or some other state agency?

YES 1
NO 2
DK
RF

FQ10.

Is {<u>FACILITY</u>} licensed as a nursing home or a nursing facility by the state health department or some other state agency?

YES	1
NO	2
DK	
RF	

FQ11.

Since {FACILITY} is not itself a licensed nursing home, is it part of a larger complex (e.g. retirement community) or a larger facility (e.g. hospital or assisted living facility) that includes a licensed nursing home or nursing facility?

YES	1
NO	2
DK	
RF	

FQ13.

Does this nursing home/nursing facility have the same name as {<u>FACILITY</u>}?

YES	1
NO	2
DK	
RF	

FQ13A.

What is the name of this facility?

VERIFY SPELLING.

FQ14.

Does {<u>FACILITY</u>} have 3 or more beds?

YES .... …   1
NO .... …..   2
DK
RF

FQ15.

Is {FACILITY} certified by {'PREFERRED' NAME FOR MEDICAID} {{or 'ALLOWED FOR' NAME FOR MEDICAID}}?

YES .... …   1
NO .... …..   2
DK
RF

FQ16.

Is {FACILITY} certified by Medicare as a skilled nursing facility (SNF)?

YES   1
NO   2
DK
RF

FQ17.

What is the Medi<u>care</u> provider number for {<u>FACILITY</u>}?

_____
MEDICARE PROVIDER NUMBER

FQ17A.

I have entered {FQ17/CareNum}. Is this correct?

YES   1
NO   2

FQ18.

What is the Medi<u>caid</u> provider number for {<u>FACILITY</u>}?

_____
MEDICAID PROVIDER NUMBER

FQ18A.

I have entered {FQ18/CaidNum}. Is this correct?

YES 1
NO 2

FQ19.

Does {<u>FACILITY</u>} provide 24-hours a day on-site supervision by an RN or LPN 7 days a week {for its nursing beds}?

YES 1
NO 2
DK
RF

FQ20.

Does {FACILITY} have a waiver?

YES 1
NO 2
DK
RF

FQ21.

Which one of these categories on this card best describes the ownership of this facility?

PRESS F1 FOR HELP SCREEN.

SHOW CARD FQ2.

FOR PROFIT.. 1
PRIVATE NONPROFIT 2
CITY/COUNTY GOVERNMENT 3
STATE GOVERNMENT 4
DEPARTMENT OF VETERANS AFFAIRS 5
OTHER FEDERAL AGENCY 6
OTHER (SPECIFY) _____ 91
DK
RF

FQ21A.
SPECIFY OWNERSHIP.

_____

FQ22.

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.

ENTER NUMBER

_____

FQ23.

In the past 12 months, that is, since {PAST 12 MONTHS}, has the number of beds increased, decreased, or remained the same in {FACILITY}?

INCREASED.. .… 1
DECREASED 2
SAME 3
DK
RF

FQ24PRE.

The next series of questions is about the number of certified and non-certified nursing home beds in this facility. A nursing home bed may be dually certified <u>both</u> by Medicare and Medicaid, certified only by Medicare, certified only by Medicaid, or not certified. A combination of these types should equal the total number of nursing home beds available to residents.

PRESS ENTER TO CONTINUE.

FQ24.

What is the total number of beds in this facility that are certified by <u>both</u> Medicare and Medicaid, dually certified?

ENTER NUMBER.

_____

FQ25.

What is the total number of beds certified by Medicaid only? {Please do not include beds counted as dually certified.}

ENTER NUMBER.

_____

FQ26.

What is the total number of beds certified by Medicare only? {Please do not include beds counted as dually certified.}

ENTER NUMBER.

_____

FQ27.

What is the total number of beds not certified by Medicaid or Medicare?

ENTER NUMBER.

_____

FQ28.

{Is this/Are any of these} {FQ27/<u>NumNotCert</u> } uncertified bed{s} licensed as {a} nursing home bed{s}?

YES 1
NO 2
DK
RF

FQ29.

How many of these {FQ27/<u>NumNotCert</u>} uncertified beds are licensed as nursing home beds?

ENTER NUMBER OF BEDS.

_____

FQ30.

Based on your most recent daily census, what is the total number of current nursing home residents?

PROBE: Please include residents for whom a bed is being held while in the hospital.

ENTER NUMBER.

_____

FQ30A. Does {FACILITY} have a waiting list?

PROBE: A waiting list refers to a list of persons who need a nursing home placement.

YES 1
NO 2
DK
RF

FQ30B. How many people are currently on the waiting list?

ENTER NUMBER OF PEOPLE.

|__|__|__|

FQ31.

How many discharges did {FACILITY} have during the calendar year?

ENTER NUMBER OF DISCHARGES.

_____

FQ32.

How many admissions did {FACILITY} have during the calendar year?

ENTER NUMBER OF ADMISSIONS.

_____

FQ33A.

Did you have a chance to fill out the Staffing Questionnaire that was sent with the appointment letter?

IF YES, ASK RESPONDENT FOR COMPLETED STAFFING QUESTIONNAIRE (SAQ).

YES, SAQ COMPLETE 1
NO, SAQ NOT COMPLETE 2

FQ33B.

At this time, I will be glad to answer any questions about the Staffing Questionnaire. (PAUSE) I can provide you with a copy of the questionnaire if needed.

ANSWER ANY QUESTION THE RESPONDENT MIGHT HAVE.

PRESS ENTER TO CONTINUE WITH NEXT ITEM.

FQ34.

INDICATE THE SAQ STATUS HERE.

LEFT SAQ WITH RESPONDENT TO PICK UP LATER TODAY 1
LEFT SAQ WITH RESPONDENT, CAN'T COMPLETE TODAY,
  RECORD APPOINTMENT DATE AND TIME FOR
  TELEPHONE FOLLOWUP ON FROG 2
REFERRED AND GIVEN TO SOMEONE ELSE
  (RECORD NAME ON FROG).. 3
OTHER (SPECIFY) _____ 91

FQ34A.
SPECIFY RESULT.

_____

FQ35.
SCAN THE SAQ. HAS IT BEEN….

COMPLETED 1
PARTIALLY COMPLETED 2

FQ35A.
Thank you for completing the SAQ. I would however like to try to obtain a few key item(s) that I see have been missing on the questionnaire. Could you please provide (ITEMS LEFT BLANK IN THE SAQ).

PRESS ENTER TO CONTINUE.

FQ36.

YOU HAVE COMPLETED FQ FOR {FACILITY}. PRESS 1 AND ENTER TO CONTINUE.

FQNAV.

YOU HAVE COMPLETED THE FQ SECTION. PRESS F3 TO CONTINUE WITH THE FC SECTION.

TO GO TO THE SAMPLING SECTION, PRESS 99 AND ENTER.

Facility Qualification Section Help Screens

FQ5

A **chain** is defined as having two or more homes under one ownership or operation.

FQ8

"Hospital" is a broad concept. It includes the following: acute care hospitals; private psychiatric hospitals; state or county hospitals for the mentally ill; Department of Veterans Affairs hospitals and medical centers; state hospitals for the mentally retarded; chronic disease, rehabilitation, geriatric, and other long-term hospitals; and other places that are commonly called hospitals.

A hospital-based skilled nursing facility (SNF) is certified by Medicare to provide skilled nursing services. It could be based within any of these hospital types.

FQ21

The facility is **for profit** if it is owned by an individual, a partnership, or a corporation.

The facility is **private nonprofit** if it is owned by a religious group or a nonprofit corporation, etc.

Facility Characteristics (FC) Module

FC1PRE. The following questions are about services, rates, special programs, and staff and other care providers.

PRESS 1 AND ENTER TO CONTINUE.

FC2. Does {FACILITY} have special, physically distinct or designated clusters of beds, or segregated wings or units, used exclusively for conditions listed on this card?

IF YES: Which ones?

PROBE: Anything else?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC1.

ALZHEIMER'S AND RELATED DEMENTIAS 1
AIDS/HIV 2
BEHAVIOR UNIT (NON-ALZHEIMER'S) 3
DISEASE-SPECIFIC (DIALYSIS, BRAIN INJURY-TRAUMATIC OR
ACQUIRED, HUNTINGTON'S DISEASE) 4
CHILDREN WITH DISABILITIES, MENTALLY RETARDED
  /DEVELOPMENTALLY DISABLED 5
HOSPICE 6
REHABILITATION (CARDIAC, FUNCTIONAL) 7
RESPITE CARE 8
SUBACUTE CARE 9
VENTILATOR/PULMONARY 10
OTHER 11
NO SPECIAL CARE UNITS 12
DK
RF

FC3A. Based on your most recent daily census, what is the number of current residents who have Medicare as their primary source of payment?

ENTER NUMBER.

|__|__|__|

FC4A. Based on your most recent daily census, what is the number of current residents who have Medi<u>caid</u> as their <u>primary</u> source of payment?

DO NOT INCLUDE RESIDENTS APPLYING FOR MEDICAID.

ENTER NUMBER.

|__|__|__|

FC5A. Based on your most recent daily census, what is the number of current residents who have self or private pay as their <u>primary</u> source of payment?

ENTER NUMBER.

PRESS F1 FOR HELP SCREEN.

|__|__|__|

FC6. What is the basic rate for Medicaid?

PRESS F1 FOR HELP SCREEN.

RESPONDENT PROVIDES A SINGLE BASE RATE 1
RESPONDENT PROVIDES A RANGE 2
DK
RF

FC6A. [What is the basic rate for Medicaid?]

ENTER {THE LOWEST} RATE.

PRESS F1 FOR HELP SCREEN.

|__|__|__|__|__|__|

FC6A1. [What is the basic rate for Medicaid?]

ENTER THE HIGHEST RATE.

PRESS F1 FOR HELP SCREEN.

|__|__|__|__|__|__|

FC6A2. [What is the basic rate for Medicaid?]

ENTER UNIT.

PER DAY.. 1
PER WEEK.. 2
PER MONTH 3

FC7. What is the basic rate for self or private pay?

PRESS F1 FOR HELP SCREEN.

RESPONDENT PROVIDES A SINGLE BASE RATE.............................. 1
RESPONDENT PROVIDES A RANGE 2
DK
RF

FC7A. [What is the basic rate for self or private pay?]

ENTER {THE LOWEST} RATE.

PRESS F1 FOR HELP SCREEN.

|__|__|__|__|__|

FC7A1. [What is the basic rate for self or private pay?]

ENTER THE HIGHEST RATE.

PRESS F1 FOR HELP SCREEN.

|__|__|__|__|__|

FC7A2. [What is the basic rate for self or private pay?]

ENTER UNIT.

PER DAY... 1
PER WEEK 2
PER MONTH... 3

FC8. Does {FACILITY} have <u>formal contracts</u> with any of the outside service providers on this card?

PROBE: Any other providers?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC2.

ASSISTED LIVING FACILITY/ORGANIZATION 1
DENTAL/ORAL SERVICES 2
DIAGNOSTIC SERVICES 3
HEARING AND VISION SERVICES 4
HOME HEALTH CARE AGENCY 5
HOSPICE 6
HOSPITAL 7
LIFE CARE/RETIREMENT COMMUNITY(S) 8
MANAGED CARE ORGANIZATION 9
MANAGEMENT GROUP 10
MEDICAL CENTER/HEALTH SYSTEM(S) 11
MEDICAL DIRECTOR 12
PHARMACY 13
PHYSICIAN GROUP 14
PODIATRY SERVICES 15
PSYCHIATRIC FACILITY/BEHAVIORAL MANAGEMENT 16
PSYCHIATRY/PSYCHOLOGY SERVICES 17
THERAPY SERVICES 18
OTHER 19
NO FORMAL CONTRACTS WITH OUTSIDE AGENCIES………………..20
DK
RF

FC9. Does {FACILITY} provide any of the services on this card? Include only services provided in the facility.

PROBE: Anything else?

SELECT ALL THAT APPLY.

SHOW CARD FC3.

DIALYSIS – HEMO.. 1
DIALYSIS – PERITONEAL... 2
INFUSION THERAPY 3
PERIPHERALLY INSERTED CENTRAL LINES
    (PIC PLACEMENT) 4
VENTILATOR/PULMONARY THERAPY 5
BLADDER SCANNER 6
BLOOD TRANSFUSIONS.. 7
PARENTERAL NUTRITION……………………………………8
NONE OF THE ABOVE SERVICES....................................... 9
DK
RF

FC10. Please tell me if this facility has a <u>special program that has specially trained personnel dedicated to the program</u> for anything listed on this card. This does not include special training that is provided to all personnel.

PROBE: Anything else?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC4.

HOSPICE 1
PALLIATIVE CARE/END OF LIFE (END STAGE/TERMINAL
CONDITION – NOT HOSPICE) 2
PAIN MANAGEMENT 3
BEHAVIOR PROBLEMS.. 4
SKIN/WOUNDS 5
CONTINENCE MANAGEMENT.. 6
DEMENTIA (INCLUDING ALZHEIMER'S DISEASE) 7
RESTORATIVE CARE.. 8
DOES NOT HAVE A SPECIAL PROGRAM FOR
ANY OF THESE CONDITIONS OR TYPES OF CARE 9
DK
RF

FC11. Does {FACILITY} participate in any of the following End-of-life Programs on this card?

PROBE: Anything else?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC5.

FIVE WISHES 1
POLST (PHYSICIAN'S ORDERS FOR LIFE-SUSTAINING
    TREATMENT) 2
LAST ACTS.. 3
NO END OF LIFE INITIATIVES 4
DK
RF

FC13. Please look at this card and tell me if your facility is accredited by any of these organizations.

PROBE: Anything else?

SELECT ALL THAT APPLY.

SHOW CARD FC6.

JOINT COMMISSION FOR ACCREDITATION OF
    HEALTHCARE ORGANIZATIONS (JCAHO) 1
REHABILITATION ACCREDITATION
    COMMISSION (CARF) 2
CONTINUING CARE ACCREDITATION
    COMMISSION (CCAC)... 3
NOT ACCREDITED 4
DK
RF

FC14. THE RESPONDENT IS…

THE FACILITY ADMINISTRATOR.. 1
NOT THE FACILITY ADMINISTRATOR 2

FC15PRE. The next few questions are about {your/the administrator's} education, certification, and tenure as facility administrator.

PRESS ENTER TO CONTINUE.

FC15. Please look at this card and tell me the <u>most advanced</u> degree or program that {you/the administrator} {have/has} completed.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC7.

HIGH SCHOOL DIPLOMA 1
ASSOCIATE DEGREE IN HEALTH CARE ADMINISTRATION
    OR LONG-TERM CARE.. 2
ASSOCIATE DEGREE – OTHER 3
BACHELOR DEGREE IN HEALTH CARE ADMINISTRATION/
    LONG-TERM CARE 4
BACHELOR DEGREE – OTHER 5
MASTERS DEGREE IN HEALTH CARE ADMINISTRATION/
    LONG-TERM CARE 6
MASTERS DEGREE – OTHER 7
DOCTORAL DEGREE IN HEALTH CARE ADMINISTRATION/
    LONG-TERM CARE.. 8
DOCTORAL DEGREE – OTHER.. 9
OTHER... 10
DK
RF

FC17. Please look at this card and tell me if {you/the administrator} {have/has} any of these certifications.

SELECT ALL THAT APPLY.

SHOW CARD FC8.

CERTIFIED NURSING HOME ADMINISTRATOR
   (CNHA) AMERICAN COLLEGE OF HEALTH
   CARE ADMINISTRATORS.……….. 1
AMERICAN NURSES CREDENTIALING CENTER (ANCC)…….. 2
NO CERTIFICATION 3
DK
RF

FC18. About how long {have/has} {you/the administrator} served as an administrator at <u>any</u> nursing home or similar type of facility, including this one?

ENTER NUMBER.

IF LESS THAN 1 MONTH, ENTER 1 MONTH.

|__|__|

FC18A. [About how long {have/has} {you/the administrator} served as an administrator at <u>any</u> nursing home or similar type of facility?]

ENTER UNIT.

IF LESS THAN 1 MONTH, ENTER 1 MONTH.

MONTH(S) 1
YEAR(S) 2

FC19. About how long {have/has} {you/the administrator} been the administrator of <u>this</u> facility?

ENTER NUMBER.

IF LESS THAN 1 MONTH, ENTER 1 MONTH.

|__|__|

FC19A. [About how long {have/has} {you/the administrator} been the administrator of <u>this</u> facility?]

ENTER UNIT.

IF LESS THAN 1 MONTH, ENTER 1 MONTH.

MONTH(S) 1
YEAR(S) 2

FC20. Which statements on this card describe how {FACILITY} provides medical services?

PROBE: Anything else?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC9.

PRIVATE PHYSICIANS FROM THE COMMUNITY................................. 1
CONTRACT WITH ONE OR MORE PHYSICIAN GROUP
    PRACTICES 2
PHYSICIANS ON STAFF 3
HEALTH CARE MANAGEMENT COMPANY... 4
OTHER.. 5
DK
RF

FC21.   Are dental or oral health services available to residents?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

YES, AT THIS FACILITY.. 1
YES, OUTSIDE THIS FACILITY 2
NO, SERVICES NOT AVAILABLE 3
DK
RF

FC22.   Are dental or oral health services available at regularly or routinely scheduled times, or on an on-call or as-needed basis only?

SELECT ALL THAT APPLY.

REGULARLY/ROUTINELY SCHEDULED TIMES 1
ON-CALL OR AS NEEDED ONLY 2
DK
RF

FC23.   Are mental health services available to residents?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

YES, AT THIS FACILITY.. 1
YES, OUTSIDE THIS FACILITY 2
NO, SERVICES NOT AVAILABLE 3
DK
RF

FC24.   Are mental health services available at regularly or routinely scheduled times, or on an on-call or as-needed basis only?

SELECT ALL THAT APPLY.

REGULARLY/ROUTINELY SCHEDULED TIMES 1
ON-CALL OR AS NEEDED ONLY 2
DK
RF

FC26. Does {FACILITY} currently use electronic information systems for any of the tasks on this card?

PROBE: Any other tasks?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC10.

ADMISSION, DISCHARGE, TRANSFER INFORMATION....................... 1
PHYSICIAN ORDERS.. 2
MEDICATION ORDERS, DRUG DISPENSING 3
LABORATORY/PROCEDURES INFORMATION.................................... 4
PATIENT MEDICAL RECORDS 5
MEDICATION ADMINISTRATION INFORMATION 6
MINIMUM DATA SET (MDS) 7
DIETARY... 8
DAILY PERSONAL CARE BY NURSING ASSISTANTS 9
BILLING/FINANCE 10
STAFFING/SCHEDULING INFORMATION 11
HUMAN RESOURCE/PERSONNEL INFORMATION..............................12
NO ELECTRONIC INFORMATION SYSTEMS..13
DK
RF

FC26B. Does this facility have any lifting devices for staff to use in lifting or transferring residents?

YES .... …1
NO   2
DK
RF

FC26C. How many?

ENTER NUMBER.

|__|__|

FC28. Are the following recreational activities on this card offered at {FACILITY}?

PROBE: Anything else?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC11.

OFF-SITE ACTIVITIES................................. 1
EVENING ACTIVITIES................................. 2
WEEKEND ACTIVITIES............................... 3
OUTDOOR ACTIVITIES............................... 4
GARDENING... 5
PETS/PET THERAPY 6
INTERGENERATIONAL ACTIVITIES 7
NONE OF THE ABOVE................................. 8
DK
RF

FC29. How are food services provided?

PROBE: Anything else?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

SHOW CARD FC12.

FOOD SERVED ON TRAYS... 1
POINT OF SERVICE FOOD DELIVERY SYSTEM................................. 2
FOOD SERVICES STAFF WHO SERVE MEALS.................................... 3
DK
RF

FC33A. For each of the following vaccines, please indicate which vaccination program {FACILITY} is currently using.

Which vaccination program best describes what is being used in your facility for <u>influenza</u>?

SHOW CARD FC13.

PRESS F1 FOR HELP SCREEN.

FACILITY-WIDE STANDING ORDERS 1
PRE-PRINTED ADMISSION ORDERS.. 2
ADVANCE PHYSICIAN/NURSE PRACTITIONER ORDERS FOR
    ALL OF THEIR PATIENTS.. 3
PERSONAL PHYSICIAN ORDER FOR EACH RESIDENT 4
NONE OF THE ABOVE 5
DK
RF

FC33B. Which additional strategies are being used in your facility for <u>influenza</u>?

PROBE: Anything else?

SELECT ALL THAT APPLY

SHOW CARD FC14.

WRITTEN VACCINATION POLICY 1
VACCINATION OFFERED TO ALL RESIDENTS IN THE FACILITY DURING FALL
    VACCINATION CAMPAIGN 2
VACCINATION OFFERED <u>THROUGHOUT</u> THE INFLUENZA SEASON
    (OCTOBER-MARCH) TO ALL RESIDENTS ADMITTED DURING
    THAT PERIOD.. 3
VERBAL CONSENT ALLOWED FOR VACCINATIONS......................... 4
SEASONAL VACCINATION CAMPAIGNS 5
PRIMARY CARE PROVIDER REMINDER PROGRAM........................... 6
CENTRALIZED TRACKING SYSTEM FOR FACILITY-WIDE RATES..... 7
ROUTINE REVIEW OF FACILITY-WIDE VACCINATION RATES 8
NONE... 9
DK
RF

FC34A. Which type of vaccination program best describes what is being used in your facility for pneumonia? Please select one.

SHOW CARD FC13.

PRESS F1 FOR HELP SCREEN.

FACILITY-WIDE STANDING ORDERS 1
PRE-PRINTED ADMISSION ORDERS.. 2
ADVANCE PHYSICIAN/NURSE PRACTITIONER ORDERS FOR
    ALL OF THEIR PATIENTS.. 3
PERSONAL PHYSICIAN ORDER FOR EACH RESIDENT 4
NONE OF THE ABOVE 5
DK
RF

FC34B. Which additional strategies are being used in your facility for pneumonia?

PROBE: Anything else?

SELECT ALL THAT APPLY.

SHOW CARD FC15.

WRITTEN VACCINATION POLICY 1
ASSESSMENT OF EACH RESIDENT'S
    VACCINATION STATUS UPON ADMISSION 2
VACCINATION OFFERED TO ALL RESIDENTS UPON ADMISSION.... 3
VERBAL CONSENT ALLOWED FOR VACCINATIONS.......................... 4
SEASONAL VACCINATION CAMPAIGNS 5
REGULARLY SCHEDULED YEAR-ROUND PROGRAM
    VACCINATION CAMPAIGNS…………………………………………6
PRIMARY CARE PROVIDER REMINDER PROGRAM.......................... 7
CENTRALIZED TRACKING SYSTEM FOR FACILITY-WIDE RATES..... 8
ROUTINE REVIEW OF FACILITY-WIDE VACCINATION RATES 9
NONE 10
DK
RF

FC37. Does {FACILITY} do any of the following to encourage employees' influenza vaccinations?

PROBE: Anything else?

SELECT ALL THAT APPLY.

SHOW CARD FC16.

VACCINATIONS RECOMMENDED... 1
VACCINATIONS OFFERED ON SITE 2
VACCINATIONS OFFERED FOR FREE 3
VACCINATIONS OFFERED AT REDUCED COST 4
STAFF INCENTIVES PROVIDED FOR VACCINATION.......................... 5
PROOF OF VACCINATION (OR CONTRAINDICATION)
   REQUIRED AS A CONDITION OF WORK/EMPLOYMENT............... 6
FURLOUGH OR PATIENT RESTRICTION POLICY FOR
   EMPLOYEES DEVELOPING INFLUENZA-LIKE ILLNESS................. 7
NONE OF THE ABOVE 8
DK
RF

FC38. What percentage of employees received a Flu shot last Flu season, that is, {LAST FLU SEASON}? Would you say…

SHOW CARD FC17.

0%, ... 1
1 to 20%, ... 2
21 to 40%, ... 3
41 to 60%, ... 4
61 to 80%, ... 5
81 to 99%, or 6
100%? 7
DK
RF

FCEND. YOU HAVE COMPLETED FC FOR {FACILITY}. PRESS 1 AND ENTER TO CONTINUE.

Facility Characteristics Section Help Screens

FC2

> **Behavior Units:** Include only those that deal with behaviors not related to Alzheimer's Disease.
>
> Examples of **disease-specific unit** include those specifically for dialysis, brain injury (traumatic or acquired), and Huntington's Disease, etc.
>
> **Rehabilitation units** may include those providing cardiac and functional rehab services.

FC5A

> **Self or private pay** includes SP's own income, family support, social security, or retirement funds.

FC7

> **Self or private pay** includes SP's own income, family support, social security, or retirement funds.
>
> If facility has private and semi-private rates, enter the lowest rate for semi-private and the highest rate for private for range.

FC6, FC6A, FC6A1, FC7A, FC7A1

> If facility has private and semi-private rates, enter the lowest rate for semi-private and the highest rate for private for range.

FC8

> **Formal contracts** refer to written financial agreements between two entities for goods and services.
>
> **Hospitals** include those offering services for acute, chronic, rehabilitation, or psychiatric illnesses.
>
> Include hospitals, **life care or retirement communities** that the {FACILITY} is part of.
>
> **Management group** refers to the agency or organization that manages the day-to-day operations of {FACILITY}.
>
> **Therapy services** include those providing PT, OT, or speech therapy services.

FC10

> **Include all the special programs that fit the definition, regardless of whether they are staffed by personnel on the facility's payroll.**
>
> **Palliative care or End-of-life programs** refer to non-hospice services that provide care for end-stage or terminal conditions.

FC11

Palliative care or End-of-life programs refer to non-hospice services that provide care for end-stage or terminal conditions.

Five Wishes is a document that helps one to express how they want to be treated (medically, emotionally, and spiritually) if they become seriously ill and cannot speak for themselves.

POLST (Physician's Orders for Life-Sustaining Treatment) – orders signed by the patient's physician that have resulted from discussions at or near the time of admission to the facility to help patients near the end of their lives reflect on the goals of their treatment. These orders are brief, simple, portable, authoritative, and highly visible. The form is usually in hot pink.

Last Acts – A national coalition to improve care and caring near the end of life. Protocols operational in most states protected people from unwanted, aggressive life-sustaining treatment by emergency medical service personnel.

FC15

Associate Degree – Other, Bachelor degree – Other, Master's degree – Other, and Doctoral - Other include degrees or programs that are not in health care or health care administration.

FC20

Physicians on staff are those hired or salaried by the facility.

Examples of **health care management company** include EverCare, etc.

FC21

Dental services include those offered by dentists or dental hygienists.

Examples of regularly or routinely scheduled times include once per week or once per month, etc.

FC23

Mental services include those offered by psychiatrists, psychologists, psychiatric nurse specialists, psychiatric social workers, licensed clinical social workers, or other professionals for mental health care.

Examples of regularly or routinely scheduled times include once per week or once per month, etc.

FC26

Patient medical records include nurse's notes, physician notes, and MDS forms.

FC28

Examples of **off-site activities** include trips or shopping, with transportation provided by the facility.

Evening activities are those offered after supper.

Outdoor activities may include any seasonally appropriate outdoor activities.

Gardening may include indoor and outdoor gardening activities.

Intergenerational activities include those with daycare or school age children.

FC29

Food served on trays are prepared in kitchens and delivered to patients.

Point of services food delivery systems serve food from steam table in the resident dining room or on the unit.

Do not count certified nursing assistants as **food service staff**.

FC33A, FC34A

Immunization Program Definitions

1.	**Facility wide standing orders**: An institutional policy authorizes appropriate nursing or other non-physician staff to immunize residents by institution- or medical director-approved protocol without the need for a written or verbal order from the resident's personal physician before administering the vaccine.

2.	**Pre-printed admission orders**: Each resident's personal physician signs the facility's preprinted admission order before administering the vaccine to the resident. The pre-printed order may address the resident's current vaccination needs as well as those in the future.

3.	**Advance physician/nurse practitioner orders for all of their patients**: Issued by an attending physician and authorizes immunization of ALL of the physician's patients who are residents of the facility.

4.	**Personal physician order for each resident**: Each resident's personal physician is responsible for signing an individual order for every vaccine before it is administered to the resident.