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FORM **NNHS-1**
(2-3-95)

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

FACILITY QUESTIONNAIRE

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 CALLS

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

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 the Acting 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.

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. Does your facility have special, physically distinct or designated clusters of beds, or segregated wings or areas, used exclusively for cognitively impaired residents?

01 ☐ Yes
02 ☐ No – *SKIP to item 7*

6. In total, how many beds are in these units and/or clusters?

_____ Total number of beds for cognitively impaired residents

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

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

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 7.

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 1994?

_____ Admissions in 1994

00 ☐ None

Section E – QUESTIONS ABOUT THE FACILITY – Continued

HAND FLASHCARD 2

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* ➶ _____

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

- 01 ☐ Yes
- 02 ☐ No
- 03 ☐ Don't know

14. 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

15. 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

16. 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

17a. 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 18a*

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

_____ Number of patients

18a. Are dentist services available in this facility?

- 01 ☐ Yes
- 02 ☐ No – *SKIP to item 19a*

HAND FLASHCARD 3

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) available on-call only
- 05 ☐ Other – *Specify* ➶ _____

Notes

Section E – QUESTIONS ABOUT THE FACILITY – Continued

19a. Are dental hygienist services available in this facility?

01 ☐ Yes
02 ☐ No – *SKIP to item 20a*

HAND FLASHCARD 4

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) available on-call only
05 ☐ Other – *Specify* _____

20a. How many full-time equivalent employees work in this facility?

_____ Total FTE employees

HAND FLASHCARD 5

b. How many FTE employees work in this facility for each of the following type of employee —

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 Equivalent
(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 Hygienist?	_____
(8) Physical Therapists?	_____
(9) Speech Pathologists and/or Audiologists?	_____
(10) Dieticians or Nutritionists?	_____
(11) Podiatrists?	_____
(12) Social Workers?	_____
(13) All others? – *Specify* _____	_____

HAND FLASHCARD 6

21. 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 ☐ Dental care
06 ☐ Other – *Specify* _____

Notes

Section E – QUESTIONS ABOUT THE FACILITY – Continued

22. 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

CHECK ITEM A	*Refer to questionnaire label*	01 ☐ 10th digit of control number = 1 – *GO to Introduction 1* 02 ☐ 10th digit of control number = 2 – *GO to Introduction 2* 03 ☐ 10th digit of control number = 3 – *GO to Introduction 3*

INTRODUCTION 1 – *READ TO RESPONDENT*

One of the purposes of this survey is to collect financial information about the amount and type of resources devoted to nursing home care. The information is collected on this Expense Questionnaire. *(Hand the Administrator the labeled NNHS-5, Expense Questionnaire.)* **This letter, similar to the one you received, serves as an introduction to the survey for the person completing this questionnaire.** *(Hand the administrator the NNHS-12, Accountant's Letter.)* **The Bureau of the Census is authorized to reimburse you $75.00 to help defray the cost for its completion.**

This booklet helps define the various terms that are used on the questionnaire. *(Hand the administrator the NNHS-5A, Expense Questionnaire Definition Booklet.)*

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 only for the purposes of the survey, and will not be disclosed or released to others for any purposes.

I will need your written permission to contact the facility's accountant or bookkeeper to ask him or her to fill in this questionnaire and return it to the address on the return envelope provided. *(Point out Section A on the NNHS-5, Expense Questionnaire to the administrator.)*

Would you please indicate the name and telephone number of the accountant? If his or her office is outside this facility, please indicate his or her address on the lines provided. Then sign on the line indicated.

If respondent agrees to do the NNHS-5, Expense Questionnaire, hand him/her the NNHS-1B, Payment Form. Ask him/her to fill out the form.

COLLECT THE NNHS-1B, PAYMENT FORM, NNHS-5, EXPENSE QUESTIONNAIRE, NNHS- 5A, EXPENSE QUESTIONNAIRE DEFINITION BOOKLET, AND NNHS-12, ACCOUNTANT'S LETTER FROM THE ADMINISTRATOR. THEN GO TO THE READ STATEMENT ON PAGE 7.

INTRODUCTION 2 – *READ TO RESPONDENT*

One of the purposes of this survey is to collect financial information about the amount and type of resources devoted to nursing home care. The information is collected on this Expense Questionnaire. *(Hand the Administrator the labeled NNHS-5, Expense Questionnaire.)* **This letter, similar to the one you received, serves as an introduction to the survey for the person completing this questionnaire.** *(Hand the administrator the NNHS-12, Accountant's Letter.)* **The Bureau of the Census is authorized to reimburse you up to $75.00 to help defray the cost for its completion. If you have to pay an accountant or bookkeeper to complete the questionnaire, please include a bill, up to $75.00 for reimbursement along with the completed questionnaire.**

This booklet helps define the various terms that are used on the questionnaire. *(Hand the administrator the NNHS-5A, Expense Questionnaire Definition Booklet.)*

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 only for the purposes of the survey, and will not be disclosed or released to others for any purposes.

I will need your written permission to contact the facility's accountant or bookkeeper to ask him or her to fill in this questionnaire and return it to the address on the return envelope provided. *(Point out Section A on the NNHS-5, Expense Questionnaire to the administrator.)*

Would you please indicate the name and telephone number of the accountant? If his or her office is outside this facility, please indicate his or her address on the lines provided. Then sign on the line indicated.

COLLECT THE NNHS-5, EXPENSE QUESTIONNAIRE, NNHS-5A, EXPENSE QUESTIONNAIRE DEFINITION BOOKLET, AND NNHS-12, ACCOUNTANT'S LETTER FROM THE ADMINISTRATOR. THEN GO TO THE READ STATEMENT ON PAGE 7.

INTRODUCTION 3 – *READ TO RESPONDENT*

One of the purposes of this survey is to collect financial information about the amount and type of resources devoted to nursing home care. The information is collected on this Expense Questionnaire. *(Hand the Administrator the labeled NNHS-5, Expense Questionnaire.)* **This letter, similar to the one you received, serves as an introduction to the survey for the person completing this questionnaire.** *(Hand the administrator the NNHS-12, Accountant's Letter.)*

This booklet helps define the various terms that are used on the questionnaire. *(Hand the administrator the NNHS-5A, Expense Questionnaire Definition Booklet.)*

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 only for the purposes of the survey, and will not be disclosed or released to others for any purposes.

I will need your written permission to contact the facility's accountant or bookkeeper to ask him or her to fill in this questionnaire and return it to the address on the return envelope provided. *(Point out Section A on the NNHS-5, Expense Questionnaire to the administrator.)*

Would you please indicate the name and telephone number of the accountant? If his or her office is outside this facility, please indicate his or her address on the lines provided. Then sign on the line indicated.

COLLECT THE NNHS-5, EXPENSE QUESTIONNAIRE, NNHS-5A, EXPENSE QUESTIONNAIRE DEFINITION BOOKLET, AND NNHS-12, ACCOUNTANT'S LETTER FROM THE ADMINISTRATOR. THEN GO TO THE READ STATEMENT BELOW.

READ **To complete this survey, I will need a list of all current residents. From this list, I will draw a sample of no more than 6 current residents.**

23a. 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.

01 ☐ Yes – *Go to item 24*
02 ☐ No – *Determine which staff member would have this knowledge and enter the name and title below.*

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 23a)* **know which staff member I should interview for those residents selected for the sample?**

Name

Title

24. 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 23a and 23b.)*.

Notes

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