

FORM **NNHS-1**
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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

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FACILITY QUESTIONNAIRE

1999 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.	
		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 05 Not a nursing home 09 Merged with (Control No.) _____
 02 Partial interview 06 Temporarily closed 10 Duplicate (Control No. of duplicate) _____
 03 Refusal 07 Not yet in operation 11 Other noninterview – *Specify* _____
 04 Unable to locate 08 No longer operating

2. Date of interview

Month	Day	Year

3. Field Representative name _____ **FR Code** _____

Notes/Comments section

01 Check this box if comments are written in this section or any other place on this questionnaire.

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 residents. 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 residents. 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.

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

- 01 Yes - GO to item 1b
- 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, so I will end this interview. I will report the situation to my immediate supervisor who will call you in a few days to verify this information. Thank you for your cooperation.

b. Does this facility provide 24 hour nursing care?

- 01 Yes
- 02 No

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 ownership, 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 —

- (a) AIDS/HIV care? 01 Yes 02 No
- (b) Alzheimer care? 01 Yes 02 No
- (c) Brain injury care? 01 Yes 02 No
- (d) Children with disabilities? 01 Yes 02 No
- (e) Cognitively impaired residents? 01 Yes 02 No
- (f) Dialysis care? 01 Yes 02 No
- (g) Hospice care? 01 Yes 02 No
- (h) Huntington disease care? 01 Yes 02 No
- (i) Rehabilitation care? 01 Yes 02 No
- (j) Sub-acute care? 01 Yes 02 No
- (k) Ventilatory/pulmonary care? 01 Yes 02 No
- (l) Other special care units? Specify
_____ 01 Yes 02 No

PART II

How many beds are in these units?

- (a) _____ beds
- (b) _____ beds
- (c) _____ beds
- (d) _____ beds
- (e) _____ beds
- (f) _____ beds
- (g) _____ beds
- (h) _____ beds
- (i) _____ beds
- (j) _____ beds
- (k) _____ beds
- (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 dually certified under BOTH Medicare and Medicaid?

_____ Number of beds certified by BOTH Medicare and Medicaid
00 None

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	
<i>SKIP TO ITEM 10a IF "MEDICARE ONLY" IN ITEM 6.</i>	
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 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 11</i>	
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 1998? _____ Admissions in 1998 00 <input type="checkbox"/> None	
HAND FLASHCARD 3 12. Does this facility offer any of the following services to residents of this facility? Mark (X) all that apply. PROBE: Any other services?	01 <input type="checkbox"/> Dental services 02 <input type="checkbox"/> Help with oral hygiene 03 <input type="checkbox"/> Home health services 04 <input type="checkbox"/> Hospice services 05 <input type="checkbox"/> Medical services 06 <input type="checkbox"/> Mental health services 07 <input type="checkbox"/> Nursing services 08 <input type="checkbox"/> Nutrition services 09 <input type="checkbox"/> Occupational therapy 10 <input type="checkbox"/> Personal care 11 <input type="checkbox"/> Physical therapy 12 <input type="checkbox"/> Podiatry services 13 <input type="checkbox"/> Prescribed medicines or nonprescribed medicines 14 <input type="checkbox"/> Sheltered employment 15 <input type="checkbox"/> Social services 16 <input type="checkbox"/> Special education 17 <input type="checkbox"/> Speech or hearing therapy 18 <input type="checkbox"/> Transportation 19 <input type="checkbox"/> Vocational rehabilitation 20 <input type="checkbox"/> Equipment or devices 21 <input type="checkbox"/> Other – <i>Specify</i> _____ _____
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. PROBE: Any other services?	00 <input type="checkbox"/> None 01 <input type="checkbox"/> Adult day care 02 <input type="checkbox"/> Dialysis 03 <input type="checkbox"/> Home health services 04 <input type="checkbox"/> Home delivered meals 05 <input type="checkbox"/> Homemaker or chore services 06 <input type="checkbox"/> Infusion therapy 07 <input type="checkbox"/> Rehabilitation therapy 08 <input type="checkbox"/> Nursing care 09 <input type="checkbox"/> Other services to non-residents – <i>Specify</i> _____ _____
Notes/Comments	

Section E - QUESTIONS ABOUT THE FACILITY - Continued

HAND FLASHCARD 5

14. Upon ADMISSION, does this facility assess each resident's need for the following clinical preventative services?

Mark (X) all that apply.

PROBE: Any other services?

- 00 None
- 01 Influenza vaccination
- 02 Pneumococcal vaccination
- 03 Tetanus-diphtheria (Td) Toxoid booster
- 04 Pap Smear
- 05 Clinical breast exam
- 06 Mammogram
- 07 Prostate exam
- 08 Prostate-Specific Antigen
- 09 Cholesterol check
- 10 Fecal Occult Blood
- 11 Sigmoidoscopy
- 12 Other - *Specify*

15. Does your facility have an organized program to offer the following vaccines to all residents:

Mark (X) one box for each program.

- (a) **Annual influenza vaccination?**
- (b) **Pneumococcal vaccine (Pneumonia vaccination)?**
- (c) **Tetanus-Diphtheria (Td) Toxoid booster?** ..

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

16. Are staff members required to be vaccinated against influenza?

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

HAND FLASHCARD 6

17. Are the following vaccines recorded in the resident's individual medical record?

Mark (X) all that apply.

- 00 None
- 01 Annual influenza vaccination
- 02 Pneumococcal vaccination (pneumonia vaccination)
- 03 Tetanus-Diphtheria (Td) Toxoid booster

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

- 01 Yes
- 02 No - *SKIP to item 19*

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

_____ Number of residents

Notes/Comments

Section E – QUESTIONS ABOUT THE FACILITY – Continued

HAND FLASHCARD 7

19. 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 (L.P.N.) 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?	_____		_____		_____

HAND FLASHCARD 8

20. 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* _____

21. What is the basic charge for private pay residents at each level of care —

- a. Skilled?**
- b. Intermediate?**
- c. Residential?**
- d. Other? – Specify** _____

- \$ _____ per 01 Day
- 02 Month
- 03 Not applicable
- \$ _____ per 01 Day
- 02 Month
- 03 Not applicable
- \$ _____ per 01 Day
- 02 Month
- 03 Not applicable

Notes/Comments

