FQ. FACILITY SCREENER QUESTIONNAIRE

(SCREENER ONLY)

RESPONDENT ROSTER

RR1-7

The Respondent Roster is a list (at the facility level) of all respondents (and potential respondents) identified in the course of data collection.

RESPONDENT ROSTER	
RR1 NAME	RR2 TITLE

RR2 Fill with entry in RR2.
Display the following list of codes in an F1 screen:

HEALTH CARE AND MEDICAL RECORDS STAFF TITLES

01 = Director Of Nursing/VP Of Nursing
02 = Assistant Director Of Nursing
03 = Head Nurse/Nurse Supervisor/Charge Nurse
04 = Nurse, Floor/Shift
05 = Social Worker/Case Worker/Activities Coordinator Or Director
06 = Medical Records Clerk/Supervisor/Director
07 = Nurses Aide

BUSINESS OR FINANCE TITLES

30 = VP For Finance
31 = Controller/Comptroller
32 = Business Office Manager
33 = Accounting Supervisor
34 = Accounting/Billing Or Accounts Receivable Clerk / Bookkeeper
35 = Electronic Data Processing Staff Member

MDS/QUALITY CONTROL TITLES

11 = MDS Coordinator/Nurse
12 = Case Mix Coordinator/Nurse
13 = Care Plan Coordinator/Nurse
14 = Quality Assurance Coordinator

ADMINISTRATIVE TITLES

21 = Owner
22 = Administrator/Executive Director
23 = Assistant Administrator/Administrator In Training
24 = Medical Director
25 = Admissions Director/Coordinator
26 = Human Resources Staff Member
27 = VP For Operations
28 = Administrative Assistant / Secretary / Receptionist

91 = OTHER (SPECIFY: _____)

RR2

What is {RESPONDENT'S NAME}'s title or position? SELECT ONE.

{TITLE CATEGORIES}

RR3-5 omitted.

SECTION FA. FACILITY DEFINITION

BOX FA1	If FA1-FA18 have already been completed, but ELIGIBILITY BLOCK (FA19-22) has not been completed for all facility parts, and a respondent is selected who was entered in FA18, go to FA17, p. 36. Others, go to FAVERIF1.

FAVERIF1

IF SP IN AN ADULT/GROUP HOME OR SIMILAR RESIDENCE AT ANOTHER LOCATION, CODE "2" OR "3" WITHOUT ASKING.

Before we begin, I need to verify that our information about you is correct.
Is {FACILITY} the exact name of this facility?

YES 1
NO 0

IF ADULT/GROUP HOME

DISPLAYED GROUP HOME NAME IS CORRECT 2
DISPLAYED GROUP HOME NAME IS NOT CORRECT 3
DK ..... -8
RF ..... -7

What is the exact name of this facility?

_____
FACILITY NAME

REASON FOR NAME UPDATE:

CORRECTING A TYPOGRAPHICAL ERROR 1
CORRECTING SOME OTHER KIND OF ERROR 2
SPECIFYING MORE COMPLETE INFORMATION 3
FACILITY CHANGED ITS NAME
WHEN BOUGHT BY ANOTHER COMPANY 5
FACILITY CHANGED ITS NAME FOR SOME
OTHER REASON 6
ADULT/GROUP HOME 9
OTHER (SPECIFY:_____) 91

FAVERIF2 moved.

FAVERIF3

{Is the address of the place where [SP NAME} lives.../Is {FACILITY}'s address...}

{ADDRESS1}
{CITY, STATE ZIP}?

YES	1
NO	0
DK	-8
RF	-7

BOX FA1A	If 0 is entered in FAVERIF3, review address fields. If interviewer pressed enter on each and all fields, go to FAVERIF4. Else, present ADDRESS UPDATE SCREEN. Set a flag to indicate a change has been made. The ADDRESS UPDATE screen collects the reason for change. Else, continue.

REASON FOR ADDRESS UPDATE: ( )

CORRECTING A TYPOGRAPHICAL ERROR	1
CORRECTING SOME OTHER KIND OF ERROR	2
SPECIFYING MORE COMPLETE INFORMATION	3
FACILITY MOVED TO A DIFFERENT ADDRESS	7
FACILITY CHANGED ITS ADDRESS FOR SOME OTHER REASON	8
ADULT/GROUP HOME	9
OTHER (SPECIFY:_____)	91

FAVERIF4

{CODE "2" WITHOUT ASKING.}

{{Is ADMINISTRATOR'S NAME} {Are you/You are}} {still} the current administrator of {FACILITY}?

YES	1
NO	0
{RESPONDENT CONSIDERED ADMINISTRATOR	2}
DK	-8
RF	-7

After the NAME has been entered and the TITLE confirmed, return to FAVERIF4 at the ADMINISTRATOR UPDATE SCREEN. The UPDATE screen captures the reason for the change:

REASON FOR ADMINISTRATOR NAME UPDATE: ( )

CORRECTING A TYPOGRAPHICAL ERROR	1
CORRECTING SOME OTHER KIND OF ERROR	2
SPECIFYING MORE COMPLETE INFORMATION	3
FACILITY CHANGED ADMINISTRATORS	4
OTHER (SPECIFY:_____)	91

FAVERIF5

{VERIFY PHONE NUMBER IS FOR FQ RESPONDENT. DO NOT READ ALOUD.}

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

YES	1
NO	0
DK	-8
RF	-7

What is the phone number?

( ) ( ) - ( )

{Area code and state do not match. Verify and re-enter state and area code.}

The second UPDATE screen collects the reason for the change:

REASON FOR UPDATE: ( )

CORRECTING A TYPOGRAPHICAL ERROR	1
CORRECTING SOME OTHER KIND OF ERROR	2
SPECIFYING MORE COMPLETE INFORMATION	3
FACILITY MOVED TO A DIFFERENT ADDRESS	7
ADULT/GROUP HOME	9
AREA CODE CHANGED	10
OTHER (SPECIFY:_____)	91

BOX FA1B	If FAVERIF1=2 or 3, go to FAVERIF3A. If baseline FQ, go to FAVERIF5A. Else, go to BOX FA2.

FAVERIF3A

Is your office address...

{ADDRESS1}
{CITY, STATE ZIP}?

YES	1
NO	0
RF	-7

BOX FA1C	If 0 is entered in FAVERIF3A, review address fields: If interviewer pressed enter on each and all fields, go to BOX FA2. Else, present ADDRESS UPDATE SCREEN. Else, go to BOX FA2.

FAVERIF5A

When was {FACILITY} founded?
ENTER A 4-DIGIT YEAR.

MONTH ( ) YEAR ( )

FAVERIF5B

Did it previously have a different name or address?

YES..... 1
NO 0 (FAVERIF6)

FAVERIF5C

What was the previous name and address?

{FACILITY}
{ADDRESS)
(CITY, STATE, ZIP}

BOX FA1D	Post name and address to the indicated variable names. Review fields: If interviewer pressed enter on each field, go to FAVERIF6. Else, continue.

FAVERIF5D

When did the name change occur?
ENTER A 4-DIGIT YEAR.

MONTH ( ) YEAR ( )

FAVERIF6

Is {FACILITY} part of a chain--that is, a group of long-term care facilities operating under common management?

YES..... 1
NO..... 0

PRESS F1 FOR EXPANDED DEFINITION.

BOX FA2	If Baseline FQ, go to FA1PRE. If fall round, go to BOX FB1A. If no FQ in or after most recent fall round, go to BOX FB1A. Else, go to CLOSING 1.

FACILITY-LEVEL QUESTIONNAIRE

FA1PRE

Now I have a few questions about the structure of {FACILITY} and its certification and licensing to confirm that it is eligible for this study.

PRESS ENTER TO CONTINUE.

BOX FA1PRE	If FAVERIF6 = 1 (YES, FACILITY IS PART OF A CHAIN), go to FA1A. Else, go to FA1.

FA1A

I understand that {FACILITY} is part of a chain -- that is, a group of long-term care facilities operating under common management. Setting that aside, this next question is about the physical location of the home here.

PRESS ENTER TO CONTINUE.

FA1

Is {FACILITY} a free-standing nursing home?
PROBE: Free-standing nursing homes are not physically part of any other place or organization.

PLACTYPE	YES	1	(FAVERIF2)
	NO	0	(FAVERIF2)

IF VOLUNTEERED: {FACILITY} IS ...

CONTINUING CARE RETIREMENT COMMUNITY (CCRC)	3	(BOX FA5)
NURSING HOME/UNIT WITHIN A CCRC OR RETIREMENT CENTER	4	(FA9)
RETIREMENT COMMUNITY	5	(BOX FA5)
HOSPITAL	6	(BOX FA5)
HOSPITAL-BASED SNF UNIT	7	(FA9)
ASSISTED LIVING FACILITY	8	(FAVERIF2)
BOARD AND CARE HOME	9	(FAVERIF2)
DOMICILIARY CARE HOME	10	(FAVERIF2)
PERSONAL CARE HOME	11	(FAVERIF2)
REST HOME/RETIREMENT HOME	12	(FAVERIF2)
MENTAL HEALTH CENTER/PSYCHIATRIC SETTING	15	(FAVERIF2)
INSTITUTION FOR THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED	16	(FAVERIF2)
REHABILITATION FACILITY	17	(FAVERIF2)
ADULT/GROUP HOME	18	(BOX FA5)
HOME/MGMT. OFFICE FOR CHAIN/OFF-SITE NURSING FACILITIES	13	(FA5A)
OTHER (SPECIFY:_____)	91	(FAVERIF2)
DK	-8	(FAVERIF2)
RF	-7	(FAVERIF2)

PRESS F1 FOR DEFINITION OF FREE-STANDING AND HOSPITAL-BASED SNFS.

FAVERIF2

IF ALREADY KNOWN, CODE WITHOUT ASKING:
Do you prefer that I call {FACILITY} a home or a facility?

PREFERS HOME	1
PREFERS FACILITY	2
NO PREFERENCE	3

BOX FA2A	If FA1 = 1, go to FA19. Else, continue.

FA2

Is {FACILITY} part of a larger {home/facility} or campus?

YES	1
NO	0
DK	-8
RF	-7

PRESS F1 FOR DEFINITION, EXAMPLES OF "LARGER" PLACES.

BOX FA3	If FA1 = 8, 9, 10, 11, 12, 15, 16, 17, or 91 and FA2 = 0, -8 or -7 go to BOX FA5. If FA2 = 1, go to FA3. Others, go to FA5.

FA3

IF ALREADY VOLUNTEERED, CODE WITHOUT ASKING:
What type of place is {FACILITY} part of?

SHOW CARD FA1

CONTINUING CARE RETIREMENT COMMUNITY (CCRC)	3
RETIREMENT COMMUNITY	5
HOSPITAL	6
ASSISTED LIVING FACILITY	8
BOARD AND CARE HOME	9
DOMICILIARY CARE HOME	10
PERSONAL CARE HOME	11
REST HOME	12
OTHER (SPECIFY:_____)	91

PRESS F1 FOR HOSPITAL DEFINITIONS.

FA4

What is the name of the {CATEGORY SELECTED IN FA3/place}?

_____

BOX FA4	Add to Place Roster, then Go to BOX FA5.

FA5

What type of place is {FACILITY}?

SHOW CARD FA2

PLACTYPE	CONTINUING CARE RETIREMENT COMMUNITY (CCRC)	3	(BOX FA5)
	NURSING HOME/UNIT WITHIN A CCRC OR RETIREMENT CENTER	4	(FA9)
	RETIREMENT COMMUNITY	5	(BOX FA5)
	HOSPITAL	6	(BOX FA5)
	HOSPITAL-BASED SNF UNIT	7	(FA9)
	ASSISTED LIVING FACILITY	8	(BOX FA5)
	BOARD AND CARE HOME	9	(BOX FA5)
	DOMICILIARY CARE HOME	10	(BOX FA5)
	PERSONAL CARE HOME	11	(BOX FA5)
	REST HOME/RETIREMENT HOME	12	(BOX FA5)
	MENTAL HEALTH CENTER/PSYCHIATRIC SETTING	15	(BOX FA5)
	INSTITUTION FOR THE MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED	16	(BOX FA5)
	REHABILITATION FACILITY	17	(BOX FA5)
	ADULT/GROUP HOME	18	(BOX FA5)
	HOME OFFICE OR MANAGEMENT OFFICE FOR A CHAIN OR GROUP OF OFF-SITE NURSING FACILITIES	13	(FA 5A)
	OTHER (SPECIFY:_____)	91	(BOX FA5)
	RF	-7	(BOX FA5)

PRESS F1 FOR HOSPITAL DEFINITIONS.

BOX FA4A omitted.

FA5A

COLLECT FACILITY CONTACT INFORMATION FOR FACILITY WHERE SP IS LOCATED (TARGET FACILITY). THEN PRESS ENTER TO CONTINUE. (CLOSING 5)

BOX FA5	If FA1 or FA5 = 18, set LOCCODE = TARGET FACILITY and go to BOX FA11. If FA3 = 6, set target facility LOCCODE = TARGET FACILITY, PART OF LARGER FACILITY, set added place LOCCODE = LARGER FACILITY, and go to FA11. If FA3 = 8-12, set added LOCCODE = PART OF LARGER FACILITY and set TARGET LOCCODE = TARGET FACILITY, PART OF LARGER FACILITY and go to FA11. If FA1 or FA5 = 8-12, 15-17, 91 -8, or -7 and FA2 = 1, set target facility LOCCODE = TARGET FACILITY, PART OF LARGER FACILITY, set added place LOCCODE = LARGER FACILITY and go to FA11. If FA1 or FA5 = 8-12, 15-17, 91, -8, or -7 and FA2 = 0, set LOCCODE = TARGET FACILITY and go to BOX FA11. If FA1 or FA5 = 3 or 5, set LOCCODE = TARGET FACILITY AND LARGER FACILITY and go to FA11. If FA1 or FA5 = 6, go to FA8. Else, set LOCCODE = LARGER FACILITY and go to FA11.

FA7 omitted.

FA8

Does {LARGER FACILITY or any of its parts/FACILITY} have any beds that are certified or licensed as a nursing {home/facility}?

Any beds certified or licensed as an ICF-MR (Intermediate Care Facility for the Mentally Retarded)?

FACLONGT	YES TO EITHER	1
	NO TO BOTH	0
	DK	-8
	RF	-7

PRESS F1 FOR SUGGESTED PROBES

BOX FA7	If FA8 = 1 and no place has LOCCODE = LARGER FACILITY, set LOCCODE = TARGET FACILITY AND LARGER FACILITY. If FA8 = 1, set RHPLACTY = HOSPITAL and go to FA11. If FA8 = 0 or -8, set RHPLACTY = HOSPITAL, set LOCCODE = TARGET FACILITY, and go to FA16. Else, go to BOX FA11.

FA9

What is the name of the {CATEGORY SELECTED IN FA1 OR FA5}?

_____

BOX FA8	Add to Place Roster. IF FA1 or FA5=7, add HOSPITAL NAME to database. Set the locator code for the place added to Place Roster =LARGER FACILITY, and set the locator code for the target facility = TARGET FACILITY, PART OF LARGER FACILITY. Then, if FA1 or FA5=7 (HOSPITAL-BASED SNF UNIT), go to FA16. Others, go to FA11.

FA10 omitted.

FA11

Please tell me about all the parts or units of {LARGER FACILITY} where residents stay overnight.
{Please do not include acute care departments or units in this list.}
{PROBE: Any others?}

FA11 NAME	FA12 PLACE TYPE	FA13 NUMBER OF BEDS/ UNITS	FA14 ANOTHER NAME? (YES = 1, NO = 0)	FA15 ALSO KNOWN AS...

PROBE: Any others?

FA12
When the cursor is in the PLACE TYPE column, in the question area above the matrix, replace question text for FA11, "Please tell me about..." with FA12.
Display the following categories and codes across the bottom of the screen whenever the cursor is in the PLACE TYPE column:

4 = NURSING HOME/UNIT
6 = HOSPITAL
8 = ASSISTED LIVING FACILITY
9 = BOARD AND CARE HOME
10 = DOMICILIARY CARE HOME
11 = PERSONAL CARE HOME
12 = REST HOME/RETIREMENT HOME
14 = INDEPENDENT LIVING UNITS
15 = MENTAL HEALTH CENTER/PSYCHIATRIC SETTING
16 = INSTITUTION FOR THE MENTALLY RETARDED/DEVELOPMENTALLY DISABLED
17 = REHABILITATION FACILITY
91 = OTHER (SPECIFY:_____)

[NOTE: These categories can be mapped to the categories and subcategories in RH22. Absolute consistency with the presentation in the residence history section is not desirable, however, because here we are asking specifically about a place that we already know is part of a larger facility; in residence history, the questions are designed to categorize the place where the SP resided, regardless of whether it was part of a larger place or not.]

FA12

SHOW CARD RH2

What type of (place/unit) is that?

PROBE WITH CATEGORIES BELOW MATRIX.

PRESS F1 FOR DEFINITION OF ASSISTED LIVING FACILITY, BOARD AND CARE HOME, DOMICILIARY CARE HOME, PERSONAL CARE HOME, AND REST HOME.

FA13

How many beds {or individual units} are in {PLACE/UNIT}?

FA14

Is {PLACE/UNIT} also known by some other name?

YES..... 1
NO ..... 0 (BOX FA10)

FA15

What name is that?

_____

ALSO KNOWN AS . . .

BOX FA9 omitted.

BOX FA10	1. Post each Part/Unit to Place Roster. 2. If target facility's locator code = TARGET FACILITY, PART OF LARGER FACILITY, code all other parts/units listed in FA11-15 as PART OF LARGER FACILITY. Else, code all parts/units as PART OF TARGET FACILITY. 3. For each Place: If FA3, FA5, or FA12 = DK or RF, set a flag for data retrieval of PLACTYPE. Else, continue. 4. If HOSPITAL created at FA11-15 (PLCREATE = 32), go to FA16 Else, go to BOX FA11.

FA16

You mentioned that {NAME IN FA11} is a hospital. Please look at this card and tell me what kind of hospital it is.

SHOW CARD FA3

A.	ACUTE CARE HOSPITAL	1
B.	PRIVATE PSYCHIATRIC HOSPITAL	2
C.	STATE OR COUNTY HOSPITAL FOR THE MENTALLY ILL	3
D.	VA HOSPITAL, VA MEDICAL CENTER	4
E.	STATE HOSPITAL FOR THE MENTALLY RETARDED	5
F.	CHRONIC DISEASE, REHABILITATION, GERIATRIC, OR OTHER LONG-TERM CARE HOSPITAL	6
	OTHER (SPECIFY:_____)	91

BOX FA11

Review Status Code and Place Type for each Place. If missing for a Place, assign a value to the missing item(s) based on the following table:

IF	THEN ASSIGN: MCBS STATUS CODE FOR TARGET FACILITIES	MCBS PLACE TYPE
FA1, FA3 or FA5 =		
3 (CCRC)	ELIGIBLE	ELIGIBLE LTC
5 (RETIREMENT COMMUNITY)	ELIGIBLE	ELIGIBLE LTC
FA1 or FA5 =		
18 ADULT/GROUP HOME	ELIGIBLE	ELIGIBLE LTC
13 (HOME OFFICE)	INELIGIBLE	COMMUNITY
FA1, FA5, or FA12 =		
8 (ASSISTED LIVING FACILITY)	ELIGIBLE	ELIGIBLE LTC
9 (BOARD AND CARE HOME)	ELIGIBLE	ELIGIBLE LTC
10 (DOMICILIARY CARE HOME)	ELIGIBLE	ELIGIBLE LTC
14 (INDEPENDENT LIVING UNITS)	INELIGIBLE	COMMUNITY
15 (MENTAL HEALTH/ PSYCHIATRIC	ELIGIBLE	ELIGIBLE LTC
4 (NURSING HOME/ UNIT)	ELIGIBLE	ELIGIBLE LTC
11 PERSONAL CARE HOME)	ELIGIBLE	ELIGIBLE LTC
12 (REST HOME)	ELIGIBLE	ELIGIBLE LTC
16 (MR/DD)	ELIGIBLE	ELIGIBLE LTC
17 (REHABILITATION FACILITY)	ELIGIBLE	ELIGIBLE LTC
91 (OTHER)	ELIGIBLE	ELIGIBLE LTC
FA1, FA3, FA5, or FA12 = DK or RF	ELIGIBLE	ELIGIBLE LTC
IF FA1, FA5, or FA12=6 AND FA16 not=1 or –1 (ANY OTHER KIND OF HOSPITAL)	ELIGIBLE	ELIGIBLE LTC

Leave blank all others with missing MCBS Status or Place Type.
No further action is required in the Facility-level Questionnaire for all Places with MCBS Status=INELIGIBLE.

Then go to FA16a (PLACROST).

FA16a (PLACROST)

HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

BOX FA12	1. If the Target Facility's locator code = TARGET FACILITY AND LARGER FACILITY, set MCBS status=ELIGIBLE. (Eligibility will be determined for its parts in the steps below.) Go to next place. If no remaining places, go to Item 5 below. 2. If Place has locator code=PART OF TARGET FACILITY, set TENTATIVE ADDITION flag = YES for this Place and go to the next Place or Item 5 below. 3. If Place has locator code=PART OF LARGER FACILITY, set TENTATIVE ADDITION flag = YES for this Place and go to the next Place or Item 5 below. 4. Unless the Place is the Target Facility, set MCBS status=INELIGIBLE for this Place and go to next Place or Item 5. 5. If the target facility's MCBS status=INELIGIBLE, and no Place is flagged TENTATIVE ADDITION, go to CLOSING 2. Else, loop through FA17 and FA18 for each TENTATIVE ADDITION. Else, if no TENTATIVE ADDITIONs, go to FA19 for MCBS FACILITY.

FA17

Would you be able to answer some questions about the certification status and bed size for {TENTATIVE ADDITION}?

YES	1
NO	0
DK	-8
RF	-7

BOX FA13	If 1 is entered in FA17: Repeat FA17 for all TENTATIVE ADDITIONS identified; if no remaining TENTATIVE ADDITIONS, go to BOX FA14. If 0, -7, or -8 is entered in FA17, go to RR1, using question text from FA18 for the NAME CELL.

FA18

Who would be the most knowledgeable person to answer questions about {TENTATIVE ADDITION}?

NAME TITLE

BOX FA14	Repeat FA17 and FA18 for each TENTATIVE ADDITION identified for this respondent. When FA17 and FA18 have been asked for all TENTATIVE ADDITIONS for this respondent, set a counter for each TENTATIVE ADDITION FOR WHICH FA17=1 (YES). If TARGET FACILITY is eligible, go to FA19 for target facility. If target facility is ineligible, and FA17=1 (YES) for Tentative Additions for this respondent, go to FA19 for first such tentative addition. Else, go to CLOSING 6.

FA19

{{Let's turn first to {FACILITY}/{Now let's turn to {FACILITY}.}}

{How many beds does {FACILITY} have?/According to the information I obtained earlier, {FACILITY} has [READ NUMBER BELOW] beds.}

FACTOBED ___{_____}
NO. OF BEDS

{PRESS ENTER TO CONTINUE/DK = -8, RF = -7.}
PRESS F1 FOR EXPANDED DEFINITION OF "BEDS".

BOX FA14A	If PLACTYPE=4, 7, or 17, go to FA20. If FA1, FA5, or FA12=16 (MR/DD), go to FA21B. If FA16=3, 5, or 6, go to FA21B. Else, go to FA22B.

FA20

Does {FACILITY} have any beds certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as a Nursing Facility (NF) beds?

IF R MENTIONS:
ICF-MR (INTERMEDIATE CARE FACILITY--MENTAL RETARDATION), SAY THAT YOU WILL ASK ABOUT THOSE IN A MOMENT.

YES 1
NO 0
DK ..... -8
RF ..... -7

FA21

Does {FACILITY} have any beds certified by Medicare as SNF beds?

YES 1
NO 0
DK ..... -8
RF ..... -7

FA21A moved to FA85.

FA21B

Does {FACILITY} have any beds certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as ICF-MR (Intermediate Care Facility for the Mentally Retarded) beds?

YES 1
NO 0
DK ..... -8
RF ..... -7

FA22

Does {FACILITY} have any beds that are {not certified by {Medicaid or Medicare} but are} licensed as nursing {home/facility} beds by the {STATE} State Health Department or by some other State or Federal agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY:_____)	2
NO, NOT LICENSED	0
DK	-8
RF	-7

BOX FA15_1	If FA20, FA21, or FA21B = 1, go to FA22B. Else, continue.

FA22A

Does {FACILITY} provide 24-hour a day, on-site supervision by an RN or LPN 7 days a week?

FHLPNURS	YES	1
	NO	0
	DK	-8
	RF	-7

FA22B

Does {FACILITY} have any beds licensed as personal care, board and care, assisted living, or domiciliary care beds by the {STATE} State Health Department or by some other state or local government agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY:_____)	2
NO, NOT LICENSED	0
DK	-8
RF	-7

FA22C

In addition to room and board, does {FACILITY/ELIGIBLE UNIT} routinely provide...

		YES=1, NO=0, DK=-8, RF=-7
ROOMCARE	Nursing or medical care?	( )
SUPRVMED	Supervision over medications?	( )
FHLPBATH	Help with bathing?	( )
FHLPDRESS	Help with dressing?	( )
FHLPSHOP	Help with correspondence/shopping?	( )
FHLPWALK	Help with walking?	( )
FHLPEAT	Help with eating?	( )
FHLPCOMM	Help with communications?	( )

BOX FA15A1	If FA22A asked for this PLACE, go to BOX FA15A. Else, continue.

FA23

Does {FACILITY} provide 24-hour a day, on-site supervision by a caregiver 7 days a week?

YES	1
NO	0
DK	-8
RF	-7

BOX FA15A	Return to FA19 for next PLACE that has FA17 = 1 (YES) for this respondent. If no remaining place, go to BOX FA16.

BOX FA16

To be deemed eligible, a place must (1) have three or more beds, and (2) be certified by Medicaid or Medicare or be licensed as a nursing home or other long-term care facility, or provide at least one personal care service, or provide 24 hour, 7 day a week supervision by a caretaker.

Subject each place looped through FA19-23 with this respondent to the steps in BOX FA16, one place at a time.

BOX FA16	1. If FA19 is less than 3, flag FACILITY/TENTATIVE ADDITION as INELIGIBLE, set Place Type = INELIGIBLE LTC, decrement counter, and go to next Place or Item 6 below. Others, go to Item 2 below. [NOTE: This means DK and REF are assumed equal to 3 or more.] 2. If FA20 or FA21 = 1 (YES, CERTIFIED BY MEDICAID OR MEDICARE) or if FA22 = 1 or 2 (LICENSED BY STATE HEALTH DEPT. OR SOME OTHER AGENCY), or FA22A=1 (PROVIDES AROUND THE CLOCK NURSING SUPERVISION AS NH) or FA22B = 1 or 2 (LICENSED BY STATE HEALTH DEPARTMENT OR OTHER AGENCY AS OTHER LONG-TERM CARE FACILITY) or FA22C = at least one "YES" response or FA23 = 1 (PROVIDES AROUND-THE-CLOCK SUPERVISION), set MCBS STATUS = ELIGIBLE and go to next Place or Item 6 below. 3. If eligibility block (FA20-23) is indeterminate, decrement counter, set a flag for retrieval, ask FA18 and go to next Place or Item 5. Others go to Item 4. 4. Set MCBS STATUS = INELIGIBLE, set Place Type = COMMUNITY, decrement counter, and go to next Place or Item 6. 5. If no remaining places for this respondent, but there are other pending tentative additions, go to CLOSING 6. Else, 6. If Group Home (FA1 or FA5=18) go to FA31. If counter > 1, go to FA24PRE. If counter = 1, go to BOX FA16A. If counter = 0, go to CLOSING 2. Else, go to FA31PRE.

FA24PRE

All of the remaining questions will refer to {FACILITY and} {[READ FAC/UNITS LISTED BELOW]} combined.

{PLACE ROSTER VERSION 5}

PRESS ENTER TO CONTINUE.

BOX FA17 omitted.

FA24a

The questions are about the number of nursing beds and residents by payor type, special care units, and staffing. Can you answer these questions about {all/both} of these places?

YES	1	(FA25)
NO	0	(RR1)
DK	-8	(FA25)
RF	-7	(RR1)

FA24b

Who would be the best person to answer questions about [READ FACILITIES/UNITS LISTED ABOVE]?

NAME _____ TITLE _____

PROGRAMMER SPECS:
After the name and title have been posted to the Respondent Roster, go to CLOSING 6.

BOX FA16A	If FA19 (NUMBER OF BEDS) never equals DK or RF and the SUM OF FA19 can be calculated, go to FA25PRE. Else, go to FA25.

FA25PRE

{From information I collected earlier, I understand that {FACILITY/[READ FAC/UNITS LISTED ABOVE]} has {SUM OF FA19, NUMBER OF BEDS IN FACILITY} nursing or long-term care beds.}

FA25

Does {FACILITY/[READ FAC/UNITS LISTED ABOVE]} have any beds that are not licensed or certified or otherwise identified as nursing or other long-term care beds?

YES	1	(FA26)
NO	0	(BOX FA18)
DK	-8	(BOX FA18)
RF	-7	(BOX FA18)

PRESS F1 FOR DEFINITION OF "OTHERWISE IDENTIFIED".

FA26
Display the following codes for TYPE across bottom of screen:

6 = HOSPITAL
14 = INDEPENDENT LIVING
91 = OTHER (SPECIFY:_____)

FA26

Please look at this card and tell me how you would describe the beds or units that are not certified or licensed or otherwise identified as nursing or other long-term care beds.

PROBE: What kind of place is it?

SHOW CARD FA5

PRESS F1 FOR MORE ON NON-LTC BEDS.

FA27

What is the name of the place or unit?
IF SAME AS TYPE, ENTER SHIFT/5. FOR ANY OTHER NAME, ENTER TEXT.

PROGRAMMER SPECS:
If FA27=SHIFT/5 (SAME AS TYPE), display "The {TYPE CATEGORY} unit" in NAME field. Truncate names as follows:

6 = HOSPITAL
14 = INDEP LIVING
91 = FIRST 12 CHARACTERS OF SPECIFIED TEXT

FA28

How many beds or individual units are dedicated to {UNIT NAME}?

_____ ( )
NUMBER

BEDS = 1
INDIVIDUAL UNITS = 2
OTHER (SPECIFY:_____) = 91

FA29

When did the (place/unit) begin operation?

YEAR ( )

PROBE: Any other non-long-term care beds or units?

FA30

So, that is a total of {NUMBER OF BEDS AND UNITS/AN UNKNOWN TOTAL OF} {beds/units/OTHER} that are <u>not</u> licensed or certified or otherwise identified as nursing or other long-term care beds (or units). Is that correct?

YES..... 1
NO..... 0

BOX17B omitted.

FA30a (PLACROST)

HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

FA31PRE

Now we are going to ask only about the parts of {FACILITY} that have beds designated as nursing or other long-term care beds.

PRESS ENTER TO CONTINUE.

BOX FA18	If FACILITY is a LARGER FACILITY or is part of a LARGER FACILITY go to BOX FA19. Others, go to FA31.

FA31

Which one of the categories on this card best describes the ownership of {FACILITY}?

SHOW CARD FA6

FACOWNED

FOR PROFIT (INDIVIDUAL, PARTNERSHIP, OR CORPORATION) 1
PRIVATE NONPROFIT (RELIGIOUS GROUP, NONPROFIT CORP., ETC.) 2
CITY/COUNTY GOVERNMENT 3
STATE GOVERNMENT 4
VETERAN'S ADMINISTRATION 5
OTHER FEDERAL AGENCY 6
OTHER (SPECIFY:_____) 91

FA32 - FA42 omitted.

BOX FA19	If FA20 and FA21 both = 1, go to FA43. Others, go to BOX FA20.

FA43

I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as Nursing Facility beds and by Medicare as Skilled Nursing Facility beds. How many beds are dually certified (that is, certified by both)?

MANDMBED _____
NO. OF BEDS

BOX FA20	If FA20 = 1, go to FA44. Others, go to BOX FA21.

FA44

{I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME {FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as Nursing Facility beds.} How many beds are certified under {"PREFERRED" NAME FOR MEDICAID} {or {ALLOWED FOR NAME(S) FOR MEDICAID}} {only}?

MCAIDBED _____
MCDSNFN NO. OF BEDS

BOX FA21	If FA21 = 1, go to FA45. Others, go to BOX FA22.

FA45

{I have recorded that {FACILITY} contains beds that are certified by Medicare as Skilled Nursing Facility beds.} How many beds are certified under Medicare {only}?

MCAREBED _____
NO. OF BEDS

BOX FA22	If FA22 = 1 or 2, go to FA45A. Others, go to BOX FA22A.

FA45A

I have recorded that {FACILITY} contains beds that are licensed as nursing facility beds but not certified by {"PREFERRED NAME" FOR MEDICAID} {(or "ALLOWED NAME(S) FOR MEDICAID)} or Medicare. How many beds are licensed but not certified as nursing home beds {only}?

MNORMBED _____
NO. OF BEDS

BOX FA22A	If FA21B=1, go FA45B Else, go to BOX FA22B.

FA45B

I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME {FOR MEDICAID}} {(or "ALLOWED NAME(S) FOR MEDICAID)} as ICF-MR (Intermediate Care Facility for the Mentally Retarded) beds. How many beds are certified as ICF-MR beds {only}?

ICFMRBED _____
MCDICFMR NO. OF BEDS

BOX FA22B	If FA22B=1 or 2, go to FA45C Else, go to BOX FA22D.

FA45C

I recorded earlier that {FACILITY} contains beds that are licensed as a personal care, board and care, assisted living, domiciliary care, or other type of long-term care beds. How many beds are licensed as one of these types of long-term care {only}?

OTLTCBED _____
NO. OF BEDS

BOX FA22D	If cannot calculate number of remaining beds, go to BOX FA22E. Others, go to FA46.

FA46

So, there are a total of { } LTC beds in the facility:
{{ } are dually certified nursing beds,}
{{ } are certified by {"PREFERRED" .....MEDICAID"} as nursing beds {only}},
{{ } are certified as nursing beds by Medicare {only},}
{{ } are not certified by Medicare or {"PREFERRED" .....MEDICAID"} but are licensed as nursing beds,}
{{ } are certified by {"PREFERRED" .....MEDICAID"} as ICF-MR beds,}
{{ } are licensed as personal care, assisted living, or other type of long-term care beds,}
{{ } are other long-term care beds which are neither certified or licensed}.

Is that correct?

CERTBEDS YES..... 1
NLTCBEDS NO..... 0

BOX FA22E	IF FA20=1 or FA21=1, or FA21B=1, go to FA47 PRE; else go to FA49.

FA47PRE

Next, I'm going to ask about the number of current residents having {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID)}, Medicare, and private pay/{"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID)} and private pay/Medicare and private pay/private pay} as their source of payment.

If you need to go get the relevant records, I can pause for a moment.

ALLOW RESPONDENT TIME TO GATHER RECORDS, IF NECESSARY.

PRESS ENTER TO CONTINUE.

BOX FA22F	If FA20 = 1, or FA21B=1, go to FA47. Else, if FA21 = 1, go to FA48. Else, go to FA49.

FA47

Based on your most recent daily census, how many current residents have {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID)} as a source of payment?

MCAIDRES _____
NUMBER OF RESIDENTS

BOX FA22G	If FA21 = 1, go to FA48. Else, go to FA49.

FA48

Based on your most recent daily census, how many current residents have Medicare as their primary source of payment?

MCARERES _____
NUMBER OF RESIDENTS

FA49

Based on your most recent daily census, how many of the current residents in {FACILITY} have private pay as their only source of payment for basic care?

PRPAYRES _____
NUMBER OF RESIDENTS

FA52

How many residents were in {FACILITY} altogether at midnight last night?

MIDNTRES _____
NUMBER OF RESIDENTS

FA53 moved to SAQ.

BOX FA22H	If FA1 or FA5 = 18, go to FR1PRE. Else, continue.

FA54

Next, we're interested in learning about any special care units within {FACILITY} -- units with a specified number of beds identified and dedicated for residents with specific needs or diagnoses. Does {FACILITY} have any special care units, such as those listed on this card?

SHOW CARD FA7

AT LEAST ONE SPECIAL CARE UNIT MENTIONED	1	
NO SPECIAL CARE UNITS	0	(BOX FA27)
DK	-8	(BOX FA27)
RF	-7	(BOX FA27)

FA55
Display the following codes for TYPE across bottom of screen:

1 = ALZHEIMER'S AND RELATED DEMENTIAS
2 = AIDS/HIV
3 = DIALYSIS
4 = CHILDREN WITH DISABILITIES
5 = BRAIN INJURY (TRAUMATIC OR ACQUIRED)
6 = HOSPICE
7 = HUNTINGTON'S DISEASE
8 = REHABILITATION
9 = VENTILATOR/PULMONARY
91 = OTHER (SPECIFY:_____)

FA55

What kind of special care unit(s) does {FACILITY} have?

SHOW CARD FA7

PRESS F1 FOR DIALYSIS DEFINITION.

FA56

PROBE: Any others?
What is the name of the unit?
IF SAME AS TYPE, ENTER SHIFT/5. FOR ANY OTHER NAME, ENTER TEXT.

FA57

How many beds are dedicated to {UNIT NAME}?

_____
NO. OF BEDS

FA59

Does {UNIT NAME} have direct care patient staff dedicated to it?

YES 1
NO 0

FA60

In what year did the unit begin operation?

YEAR ( )

FA61

Is any resident's care in the unit paid for by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})}?

YES 1
NO 0
DK 8
RF ..... -7

FA62 omitted.

FA63

Is any resident's care in the unit paid for by Medicare?

YES	1
NO	0
DK	-8
RF	-7

FA64 omitted.

BOX FA23	If sum of FA19 minus SUM OF BEDS OR UNITS IN FA28 minus SUM OF BEDS in FA57 > 0, go to FA65. If sum of FA19 minus SUM OF BEDS OR UNITS IN FA28 minus the SUM OF BEDS in FA57 < 0, present the following message: THE NUMBER OF BEDS IN SPECIAL CARE UNITS (SUM OF FA57) CANNOT BE GREATER THAN THE TOTAL NUMBER OF BEDS IN THE FACILITY (SUM OF FA19). BACK UP, REVIEW ENTRIES IN FA57, FA19, AND FA13 CORRECT IF NECESSARY. If sum of FA19 minus SUM OF BEDS OR UNITS IN FA28 minus SUM OF BEDS in FA57 = 0, go to Box FA23a. Others, if FA65 and FA66 have not been asked, go to FA65. Else, go to BOX FA23a.

FA65

{So that makes a total of {SUM OF BEDS IN FA57} special care unit beds in {FACILITY}. You told me earlier that there are {SUM OF NUMBER OF BEDS IN FA43, FA44, FA45, FA45A} certified or licensed nursing {home/facility} beds in {FACILITY} altogether.

So that leaves {DIFFERENCE/some number of} beds that are not part of a special care unit.
Is that correct?

YES	1
NO	0
DK	-8
RF	-7

FA66

What can I call that part of {FACILITY} -- the general population unit, or do you have another name for these beds?

IF GENERAL POPULATION UNIT, ENTER SHIFT/5. FOR ANY OTHER NAME, ENTER TEXT.

BOX FA23a	Post all Places added in FA55-66 to the Place Roster. Set MCBS STATUS = ELIGIBLE; If {FACILITY} fill in FA25 is filled with PLACE NAME from Place Roster (this means there is only one eligible place), set locator code = PART OF TARGET FACILITY; else if {FACILITY} fill in FA25 is filled with "[READ FACILITIES/UNITS IN HEADER ABOVE.]", set locator code = PART OF LARGER FACILITY. set Place Type = ELIGIBLE LONG-TERM CARE.

FA66a (PLACROST)

HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

FA67PRE through FA76 omitted.

BOX FA27	If {FACILITY} locator code = PART OF LARGER FACILITY or PART OF TARGET FACILITY, or TARGET FACILITY, PART OF LARGER FACILITY, or TARGET FACILITY AND LARGER FACILITY go to FA77PRE. Others, go to FR1PRE1.

FA77PRE

The next question is about {LARGER FACILITY} as a whole.

PRESS THE F2 KEY TO REVIEW PLACE ROSTER.

PRESS ENTER TO CONTINUE.

FA77

Which one of the categories on this card best describes the ownership of {LARGER FACILITY}?

SHOW CARD FA6

FOR PROFIT (INDIVIDUAL, PARTNERSHIP, OR CORPORATION)	1
PRIVATE NONPROFIT (RELIGIOUS GROUP, NONPROFIT CORP., ETC.)	2
CITY/COUNTY GOVERNMENT	3
STATE GOVERNMENT	4
VETERAN'S ADMINISTRATION	5
OTHER FEDERAL AGENCY	6
OTHER (SPECIFY:_____)	91

BOX FA24	Go to FR1PRE1.

FA78 through FA84A omitted.

SECTION FB
LTC ELIGIBILITY BLOCK

BOX FB1A	IF THIS FACILITY WAS DETERMINED TO BE COMPLEX AT BASELINE (FACL.COMPLEXF = 1), GO TO FB0PRE; ELSE, GO TO FB1PRE.

FBOPRE
HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

FB0A

Would you be able to answer some questions about the certification status, services offered, and the number of beds for [READ PLACES LISTED BELOW]?

{ELIGIBLE PARTS OF FACILITY}

YES	1	(FB1PRE)
NO	0	(FB5O)
DK	-8	(FB5O)
RF	-7	(FB5O)

BOX FB1B omitted.

FB1PRE

I would like to review with you some information that I collected about {FACILITY/[READ FAC/UNITS LISTED ABOVE]} the last time I was here.
PRESS ENTER TO CONTINUE.

BOX FB2	If all PLAC.CAIDCRT1 = -1, go to BOX FB4. Else, if FACL.MCAIDCRT = 1, go to FB1. Otherwise, go to FB2.

FB1

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still certified by Medicaid as a Nursing Facility (NF)?

YES	1	(BOX FB3)
NO	0	(BOX FB3)

FB2

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} certified by Medicaid as a Nursing Facility (NF)?

YES	1	
NO	0	(BOX FB3)

FB4

Based on your most recent daily census, how many current residents have {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as a source of payment?

_____
OF MEDICAID RESIDENTS

BOX FB3	If FACL.MCARECRT = 1, go to FB5; Else, go to FB6.

FB5

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still certified by Medicare as a Skilled Nursing Facility (SNF)?

YES 1 (FB10)
NO 0 (FB10)

FB6

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} certified by Medicare as a Skilled Nursing Facility (SNF)?

YES 1
NO 0 (FB10)

FB8

Based on your most recent daily census, how many current residents have Medicare as their primary source of payment?

_____
OF MEDICARE RESIDENTS

FB10

Based on your most recent daily census, how many of the current residents in {FACILITY/[READ FAC/UNITS LISTED ABOVE]} have private pay as their only source of payment for basic care?

_____
OF PRIVATE PAY RESIDENTS

BOX FB4	If FACL.ICFMRCRT = 1, go to FB11. Else, if any PLAC.CAIDICF ^ = -1, go to FB12. Otherwise, go to BOX FB4A.

FB11

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still certified by Medicaid as an Intermediate Care Facility for the Mentally Retarded (ICF/MR)?

YES ..... 1 (BOX FB4A)
NO ..... 0 (BOX FB4A)

FB12

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} certified by Medicaid as an Intermediate Care Facility for the Mentally Retarded (ICF/MR)?

YES	1
NO	0

BOX FB4A	If any FACL.HDLICCRT = 1 or 2, continue. Else, if any PLACTYPE = 4 or 7 and is not a special care unit, go to FB22. Otherwise, go to BOX FB4C.

FB14

Does {FACILITY} still have beds that are {not certified by {Medicaid or Medicare} but are} licensed as nursing home beds by {the {STATE} State Health Department or by some other State or Federal agency}?

YES	1	(BOX FB4C)
NO	0	(BOX FB4C)

FB22

Does {FACILITY} have any beds that are {not certified by {Medicaid or Medicare} but are} licensed as nursing {home/facility} beds by the {STATE} State Health Department or by some other State or Federal agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY:_____)	2
NO, NOT LICENSED	0

BOX FB4B	If facility is now Medicaid or Medicare certified, go to BOX FB4C. Else, continue.

FB16

Does {FACILITY} provide 24-hours a day, on-site supervision by an RN or LPN 7 days a week?

YES	1
NO	0

BOX FB4C	If facility licensed as a personal care home, board and care home, assisted living facility, domiciliary care home or rest home by the {STATE} State Health Department or by some other state agency (FA22B=1 or 2), go to FB48. Else, go to FB47.

FB48

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still licensed as a personal care home, board and care home, assisted living facility, domiciliary care home or rest home by the {STATE} State Health Department or by some other state or local government agency?

YES	1	(FB22C)
NO	0	(FB22C)

FB47

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} licensed as a personal care home, board and care home, assisted living facility, domiciliary care home or rest home by the {STATE} State Health Department or by some other state or local government agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY): _____).....	2
NO, NOT LICENSED	0

FB22C

In addition to room and board, does {FACILITY/ELIGIBLE UNIT} routinely provide...

	YES=1, NO=0
Nursing or medical care?	( )
Supervision over medications?	( )
Help with bathing?	( )
Help with dressing?	( )
Help with correspondence/shopping?	( )
Help with walking?	( )
Help with eating?	( )
Help with communications?	( )

BOX FB6	If FB16 asked, go to BOX FB7. Else, continue.

FB23

Does {FACILITY} provide 24-hour a day, on-site supervision by a caregiver 7 days a week?

YES.....	1	(BOX FB7A)
NO.....	0	(BOX FB7)
DK.....	-8	(FB50)
RF	-7	(FB50)

BOX FB7	If now certified by Medicaid or Medicare <u>or</u> licensed as a nursing home and having 24-hour nursing supervision <u>or</u> licensed or personal care, board and care, assisted living, domicilary care, or rest, continue. Else, set MCBS STATUS = INELIGIBLE and go to CLOSING2.

BOX FB7A	If number of beds missing from baseline or previous fall round FQ, go to FB19A. Else, continue.

ELIGIBLE-BEDS COUNT BLOCK

FB19

I have recorded that {FACILITY} has [READ NUMBER BELOW] beds that provide long-term care. Is this still the number of beds providing long-term care in {FACILITY} {and [READ FAC/UNITS LISTED BELOW]}?

___{_____}___
NO. OF BEDS

{ELIGIBLE PARTS OF FACILITY}

YES..... 1 (BOX FB8)
NO..... 0

FB19A

How many beds that provide long-term care does {FACILITY} have?

PROBE: {Only count the beds in {FACILITY} and [READ FAC/UNITS LISTED BELOW].} Do not count "independent living" beds or those that don't provide 24-hour-a-day assistance or supervision with daily living activities.

_____
NO. OF BEDS

{ELIGIBLE PARTS OF FACILITY} (BOX FB8)

FB50

Who would be the best person to answer these questions about [READ FACILITIES/UNITS LISTED ABOVE]?

_____ _____
NAME TITLE

PROGRAMMER SPECS:
After the name and title have been posted to the Respondent Roster,
If coming from FB23 or before, keep responses through FAVERIF6 and go to CLOSING 6.
Else, keep responses through FB23 and go to CLOSING 6.

BOX FB8	If FB19A < 3, set MCBS STATUS=INELIGIBLE and go to CLOSING2. If now certified by both Medicaid and Medicare, go to FB43. Else, go to BOX FB9.

FB43

I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as Nursing Facility beds and by Medicare as Skilled Nursing Facility beds. How many beds are dually certified (that is, certified by both)?

_____
NO. OF BEDS

BOX FB9	If now Medicaid certified, go to FB44. Others, go to BOX FB10.

FB44

{I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME {FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as Nursing Facility beds.} How many beds are certified under {"PREFERRED" NAME FOR MEDICAID} {or {ALLOWED FOR NAME(S) FOR MEDICAID}} {only}?

_____
NO. OF BEDS

BOX FB10	If now Medicare certified, go to FB45. Others, go to BOX FB11.

FB45

{I have recorded that {FACILITY} contains beds that are certified by Medicare as Skilled Nursing Facility beds.} How many beds are certified under Medicare {only}?

_____
NO. OF BEDS

BOX FB11	If now licensed for NH beds but not certified, go to FB45A. Others, go to BOX FB12.

FB45A

I have recorded that {FACILITY} contains beds that are licensed as nursing facility beds but not certified by {"PREFERRED NAME" FOR MEDICAID} {(or "ALLOWED NAME(S) FOR MEDICAID)} or Medicare. How many beds are licensed but not certified as nursing home beds {only}?

_____
NO. OF BEDS

BOX FB12	If now ICF-MR Medicaid certified, go FB45B Else, go to BOX FB13.

FB45B

I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME {FOR MEDICAID}} {(or "ALLOWED NAME(S) FOR MEDICAID)} as ICF-MR (Intermediate Care Facility for the Mentally Retarded) beds. How many beds are certified as ICF-MR beds {only}?

_____
NO. OF BEDS

BOX FB13	If FA22B=1 or 2, go to FB45C Else, go to BOX FB14.

FB45C

I recorded earlier that {FACILITY} contains beds that are licensed as a personal care, board and care, assisted living, domiciliary care, or other type of long-term care beds. How many beds are licensed as one of these types of long-term care {only}?

_____
NO. OF BEDS

BOX FB14	If cannot calculate number of remaining beds, go to FR1PRE. Others, go to FB46.

FB46

So, there are a total of { } LTC beds in the facility:
{{ } are dually certified nursing beds,}
{{ } are certified by {"PREFERRED" .....MEDICAID"} as nursing beds {only}},
{{ } are certified as nursing beds by Medicare {only},}
{{ } are not certified by Medicare or {"PREFERRED" .....MEDICAID"} but are licensed as nursing beds,}
{{ } are certified by {"PREFERRED" .....MEDICAID"} as ICF-MR beds,}
{{ } are licensed as personal care, assisted living, or other type of long-term care beds,}
{{ } are other long-term care beds which are neither certified or licensed}.

Is that correct?

YES..... 1
NO 0

SECTION FR. FACILITY RATE SCHEDULE

FR1PRE

Next, I'd like to get some information on the basic rates residents in [READ FACILITY/UNITS ABOVE] are charged. (Most {facilities/homes} have one or more set rates they charge their residents for room and board and basic services. Usually this rate includes basic nursing services and sometimes it includes medical services as well. I'm interested in the basic rates charged by {FACILITY} for {{"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID}),} private pay, {and Medicare} residents. If you have a preprinted schedule of any of these rates, I would like to have a copy.)

PRINTED RATE SCHEDULE PROVIDED.....	1	
PRINTED RATE SCHEDULE WILL BE AVAILABLE LATER TODAY (SPECIFY WHEN AND FROM WHOM:_____).....	2	
NO PRINTED RATE SCHEDULE AVAILABLE.....	0	(FA85PRE)

PRESS F2 TO REVIEW THE PLACE ROSTER.

BOX FR1	If 1 entered in FR1PRE, go to FR1 Else, go to FA85PRE.

FR1

Is private pay on the rate schedule?

YES	1
NO	0
DK	-8

BOX FR2	If {FACILITY} now certified by Medicaid, go to FR5. Else go to BOX FR3.

FR5

Is {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} on the rate schedule?

YES	1
NO	0
DK	-8

BOX FR3	If {Facility} now certified by Medicare, go to FR6. Else go to FA85PRE.

FR6

Is Medicare on the rate schedule?

YES	1	(FA85PRE)
NO	0	(FA85PRE)
DK.....	-8	(FA85PRE)

FA85PRE

{Since you do not have a printed rate schedule,/Next, we need your Medicaid and Medicare provider numbers.} I have a short questionnaire I can leave with you to pick up later today, or I can make arrangements to give it to someone else to fill out later if you prefer. {The questionnaire asks about your basic rates and your Medicare and Medicaid provider numbers./The questionnaire also asks about facility rates. You may omit the questions which can be answered with the printed rate schedule.}

RECORD THE FOLLOWING VERBATIM IN BLANK LINE AT TOP OF FIRST SAQ PAGE
IF PROVIDER NUMBER(S) IMMEDIATELY AVAILABLE, RECORD THEM IN SAQ.

{PLACE ROSTER, VERSION 5}

FA85

SHOW SAQ TO R. INDICATE RESULTS HERE. ( )

IF YOU COMPLETED SAQ, CHECK BOX, "INT. COMP.", ON INSIDE BACK COVER OF SAQ.

LEFT SAQ WITH R TO PICK UP LATER TODAY..... 1
LEFT SAQ WITH R, CAN'T COMPLETE TODAY, RECORD APPOINTMENT DATE AND TIME FOR TELEPHONE FOLLOWUP ON FROG..... 2
REFERRED TO SOMEONE ELSE (RECORD NAME ON FROG) 3
SAQ COMPLETE..... 4
OTHER (SPECIFY: _____)..... 91

Have SAQ items been collected?

YES 1
NO 0

BOX FR4	If coming from FB section, go to CLOSING1. Else, continue.

SECTION FG: FACILITY RECORDS ORGANIZATION GRID

FG1PRE

Next, I need some information about the organization of {FACILITY}'s records and staff responsibilities.

PRESS F2 TO REVIEW PLACE ROSTER.

PRESS ENTER TO CONTINUE.

FG1 omitted.

FG1A omitted.

FG2 moved into FG4.

FG2a and FG2b omitted.

FG3

RESIDENCE HISTORY RECORDS: I may need information about where [READ SP NAME(S) FROM CASE INFORMATION SHEET] lived prior to entering {FACILITY}, and if (he/she/they) (has/have) left, where (he/she/they) went. What is the name and title of the staff member who would be the best source for this information?

RECORD NAME AND TITLE ON PAPER FROG.

PRESS ENTER TO CONTINUE.

FG4

HEALTH STATUS RECORDS: I will also need some information about [SP(s)] health status at the time of admission to {FACILITY} and about the MDS forms. What are the names and titles of the staff members who would be the best source for this information?

RECORD NAME AND TITLE ON PAPER FROG.

IF LOCATED OUTSIDE FACILITY, PROBE FOR ADDRESS.

PRESCRIPTION MEDICINE RECORDS: I will also be collecting information about the use of prescribed medicines. Who would be the best source for this information? (What is (his/her) title?)

RECORD NAME AND TITLE ON PAPER FROG.

PRESS ENTER TO CONTINUE.

FG4A

HEALTH CARE SERVICES: I will also need information about the health care services [SP(S)] may have received this year - services outside this {facili} as well as care from any physicians, therapists, or other providers who saw residents here. What staff member would be the best source for this information? Could you tell me (his/her) title?

RECORD NAME AND TITLE ON PAPER FROG.

PRESS ENTER TO CONTINUE.

FG5

BACKGROUND RECORDS: I will also be collecting some background information such as the resident's age, education, and other demographic characteristics. What is the name and title of the person who would be the best source for this information?

RECORD NAME AND TITLE ON PAPER FROG.

HEALTH INSURANCE RECORDS: I will also be collecting information on sources of health insurance coverage for residents. What is the name and title of the staff member who would be the best source for this information?

RECORD NAME AND TITLE ON PAPER FROG.

PRESS ENTER TO CONTINUE.

FG5A

EXPENDITURE RECORDS: I'll also need to talk to someone about billing and payments received for services provided.

What is the name and title of the person I should talk to about this kind of information?

RECORD NAME AND TITLE ON PAPER FROG.

PRESS ENTER TO CONTINUE.

FG6-11 omitted.

BOXES FG1 and FG2 omitted.

BOX FA29 omitted.

CLOSING 1

Thank you.
THE FACILITY-LEVEL QUESTIONS FOR THIS CASE ARE COMPLETE FOR THIS ROUND.

PRESS ENTER TO RETURN TO FACILITY NAVIGATION SCREEN.

CLOSING 2

Thank you. Those are all the questions I have for you at the moment. We will want to interview (SP NAME(S)) in the near future.

PRESS ENTER TO RETURN TO FACILITY NAVIGATION SCREEN.

CALL HOME SUMMARY REPORT omitted.

CLOSING 3 omitted.

CLOSING 4 omitted.

CLOSING 5

Thank you. Those are all the questions I have for you at the moment for this {FACILITY}. Someone from my office may call you to verify some of the data I have collected. We appreciate your help on this important study.

PRESS ENTER TO RETURN TO FACILITY NAVIGATION SCREEN.

CLOSING 6

Thank you. Those are all the questions I have for you at the moment. Right now, I need to make arrangements to speak to {NAMED RESPONDENT}.

PRESS ENTER TO RETURN TO FACILITY NAVIGATION SCREEN.

CLOSING 7 omitted.

SECTION MD: FACILITY MISSING DATA

RETRIEVE FACILITY LEVEL MISSING DATA

FQ_MISS1

THE FOLLOWING ITEMS ARE MISSING FROM FQ.
CONFIRM THAT RESPONDENT CAN ANSWER AT LEAST ONE QUESTION.

{FAVERIF1	IS SF'S NAME CORRECT?}
{FAVERIF3	IS SF'S ADDRESS CORRECT?}
{FAVERIF4	IS SF'S ADMINISTRATOR CORRECT?}
{FAVERIF5	IS SF'S PHONE NUMBER CORRECT?}
{FA_PLACE	TYPE FOR {PLACE NAME}?}
{FA19	NUMBER OF BEDS IN{FACILITY/TENTATIVE ADDITION}?}
{FA20	MEDICAID CERTIFICATION FOR {FACILITY/TENTATIVE ADDITION}?}
{FA21	MEDICARE CERTIFICATION FOR {FACILITY/TENTATIVE ADDITION}?}
{FA21B	MEDICAID-ICF/MR CERTIFICATION FOR {FACILITY/TENTATIVE ADDITION}?}
{FA22	STATE DEPARTMENT LICENSING FOR{FACILITY/TENTATIVE ADDITION}?}
{FA22B	NON-NURSING LICENSING FOR {FACILITY/TENTATIVE ADDITION}?}
{FA85	SAQ MISSING FOR{FACILITY/ELIGIBLE UNIT}}
{FR1PRE	RATE SCHEDULE MISSING FOR {FACILITY/ELIGIBLE UNIT}}

PRESS ENTER TO CONTINUE.

FAVERIF1

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

Is {FACILITY} the exact name of this {home/facility}?

YES	1
NO	0
DK	-8
RF	-7

What is the exact name of this facility?

_____
FACILITY NAME

Set a flag to indicate a change has been made. Use the updated FACILITY name for FACILITY. Fill in all questions that follow. The second UPDATE screen captures the reason for change:

REASON FOR NAME UPDATE:

CORRECTING A TYPOGRAPHICAL ERROR	1
CORRECTING SOME OTHER KIND OF ERROR	2
SPECIFYING MORE COMPLETE INFORMATION	3
FACILITY CHANGED ITS NAME WHEN BOUGHT BY ANOTHER COMPANY	5
FACILITY CHANGED ITS NAME FOR SOME OTHER REASON	6
OTHER (SPECIFY:_____)	91

FAVERIF3

{Is the address of the place where [SP NAME} lives.../Is {FACILITY}'s address...}

{ADDRESS1}
{CITY, STATE ZIP}?

YES 1
NO 0
DK ..... -8
RF ..... -7

REASON FOR ADDRESS UPDATE:

CORRECTING A TYPOGRAPHICAL ERROR 1
CORRECTING SOME OTHER KIND OF ERROR 2
SPECIFYING MORE COMPLETE INFORMATION 3
FACILITY MOVED TO A DIFFERENT ADDRESS 7
FACILITY CHANGED ITS ADDRESS FOR
SOME OTHER REASON 8
OTHER (SPECIFY:_____) 91

BOX FA1A	If 0 is entered in FAVERIF3, review address fields. If interviewer pressed enter on each and all fields, go to FAVERIF4. Else, present ADDRESS UPDATE SCREEN. Set a flag to indicate a change has been made. The ADDRESS UPDATE screen collects the reason for change. Else, continue.

FAVERIF4

{CODE "2" WITHOUT ASKING.}

{{Is ADMINISTRATOR'S NAME} {Are you/You are}} {still} the current administrator of {FACILITY}?

YES 1
NO 0
{RESPONDENT CONSIDERED ADMINISTRATOR ..... 2}
DK ..... -8
RF ..... -7

What is the current administrator's name?

After the NAME has been entered and the TITLE confirmed, return to FAVERIF4 at the ADMINISTRATOR UPDATE SCREEN. The UPDATE screen captures the reason for the change:

REASON FOR ADMINISTRATOR NAME UPDATE: ( )

CORRECTING A TYPOGRAPHICAL ERROR 1
CORRECTING SOME OTHER KIND OF ERROR 2
SPECIFYING MORE COMPLETE INFORMATION 3
FACILITY CHANGED ADMINISTRATORS 4
OTHER (SPECIFY:_____) 91

FAVERIF5

{VERIFY PHONE NUMBER IS FOR FQ RESPONDENT. DO NOT READ ALOUD.}

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

YES 1
NO 0
DK ..... -8
RF ..... -7

What is the phone number?

( ) ( ) - ( )

{Area code and state do not match. Verify and re-enter state and area code.}

The second UPDATE screen collects the reason for the change:

REASON FOR UPDATE: ( )

CORRECTING A TYPOGRAPHICAL ERROR 1
CORRECTING SOME OTHER KIND OF ERROR 2
SPECIFYING MORE COMPLETE INFORMATION.....3
FACILITY MOVED TO A DIFFERENT ADDRESS 7
ADULT/GROUP HOME 9
AREA CODE CHANGED.....10
OTHER (SPECIFY:_____).....91

FA_PLACE

What type of place is {FACILITY/PLACE/UNIT}?

SHOW CARD RH2

NURSING HOME/UNIT 4
HOSPITAL 6
ASSISTED LIVING FACILITY..... 8
BOARD AND CARE HOME 9
DOMICILIARY CARE HOME 10
PERSONAL CARE HOME 11
REST HOME/RETIREMENT HOME 12
INDEPENDENT LIVING UNITS ... 14
MENTAL HEALTH CENTER/ PSYCHIATRIC SETTING 15
INSTITUTION FOR THE MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED 16
REHABILITATION FACILITY..... 17
OTHER (SPECIFY:_____) ... 91
REFUSED ..... -7

PRESS F1 FOR DEFINITIONS OF ASSISTED LIVING FACILITY, BOARD AND CARE HOME, DOMICILIARY CARE HOME, PERSONAL CARE HOME, AND REST HOME.

FA19

{Now let's turn to {FACILITY}.}

{How many beds does {FACILITY} have?/According to the information I obtained earlier, {FACILITY} has [READ NUMBER BELOW] beds.}

__{____}
NO. OF BEDS

{PRESS ENTER TO CONTINUE/DK=-8, RF=-7.}
PRESS F1 FOR EXPANDED DEFINITION OF "BEDS".

FA20

Is {FACILITY} certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as a Nursing Facility (NF)?

IF R MENTIONS:
-ICF (INTERMEDIATE CARE FACILITY), NOTE IN COMMENTS AND ENTER 1.
-ICF-MR (INTERMEDIATE CARE FACILITY-MENTAL RETARDATION), NOTE IN COMMENTS AND ENTER 0.

YES	1
NO	0
DK	-8
RF	-7

FA21

Is {FACILITY} certified by Medicare as a SNF?

YES	1
NO	0
DK	-8
RF	-7

FA21B

Does {FACILITY} have any beds certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as ICF-MR (Intermediate Care Facility for the Mentally Retarded) beds?

YES	1
NO	0
DK	-8
RF	-7

FA22

Is {FACILITY} licensed as a nursing {home/facility} by the {STATE} State Health Department or by some other agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY:_____)	2
NO, NOT LICENSED	0
DK	-8
RF	-7

FA22B

Does {FACILITY} have any beds licensed as personal care, board and care, assisted living, or domiciliary care beds by the {STATE} State Health Department or by some other state agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY:_____)	2
NO, NOT LICENSED	0
DK	-8
RF	-7

FA23 omitted.

FA31 omitted.

FA77 omitted.

BOX FACOMP	If there is no facility missing data, that is, there are no items listed on FQ_MISS1, and FA85=2 or 4, and FR1PRE=1 or 0, go to FAEND; else go to MD Management screen (FQ_MISS).

FAEND

YOU HAVE COMPLETED DATA COLLECTION FOR FACILITY LEVEL MISSING DATA.

PRESS ENTER TO RETURN TO FACILITY NAVIGATION SCREEN.