

FORM **NNHS-3**
(2-26-97)

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

**CURRENT RESIDENT
QUESTIONNAIRE**

1997 NATIONAL NURSING HOME SURVEY

NOTICE – Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0353) Rm. 531-H; H.H. Humphrey Bldg., 200 Independence Ave., SW; Washington, DC 20201. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Section A – ADMINISTRATIVE INFORMATION

1. Field representative name

2. FR code

3. Date of interview

Month		Day		Year	

Section B – RESIDENT INFORMATION

1. Resident name or other identifier
First

M.I.

Last

2. Resident line number

Section C – STATUS OF INTERVIEW

- 01 Complete
- 02 Partial
- 03 Resident included in sampling list in error
- 04 Incorrect sample line number selected
- 05 Refused
- 06 Unable to locate record

- 07 Less than 6 residents selected
- 08 Other noninterview – *Specify*

09 No current residents

Notes

Read to each new respondent.

In order to obtain national level data about the residents of nursing homes such as this one, we are collecting information about a sample of current residents. I will be asking questions about the background, health status, and charges for each sampled resident.

The identifying information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.

Do you have the medical file(s) and record(s) for (Read name(s) of selected current resident(s))? If you have a Health Care Finance Administration Minimum Data Set for Nursing Home Resident Assessment form in the records, you may use it while we complete this questionnaire.

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the current resident forms while the respondent gets the records. If no record is available for a resident, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is ...'s sex?

- 01 Male
- 02 Female

2. What is ...'s date of birth?

Current age

Month	Day	Year

OR _____
Years

HAND FLASHCARD 1.

3a. Which of these best describes ...'s race?

Mark (X) only one box.

- 01 White
- 02 Black
- 03 American Indian, Eskimo, Aleut
- 04 Asian, Pacific Islander
- 05 Other – Specify _____
- 06 Don't know

b. Is ... of Hispanic origin?

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

4. What is ...'s current marital status?

Mark (X) only one box.

- 01 Married
- 02 Widowed
- 03 Divorced
- 04 Separated
- 05 Never Married
- 06 Single
- 07 Don't know

HAND FLASHCARD 2.

5a. Where was ... staying immediately before entering this facility?

Mark (X) only one box.

- 01 Private residence
 - 02 Rented room, boarding house
 - 03 Retirement home
 - 04 Board and care or residential care facility
 - 05 Nursing home
 - 06 Hospital
 - 07 Mental health facility
 - 08 Other – Specify _____
 - 09 Don't Know
- } SKIP to item 6 Introduction

b. At that time, was ... living with family members, nonfamily members, both family and nonfamily members, or alone?

- 01 With family members
- 02 With nonfamily members
- 03 With both family members and nonfamily members
- 04 Alone
- 05 Don't know

Read the introductory paragraph for the Social Security Number only once for each respondent.

As part of this survey, we would like to have . . .'s Social Security Number. Provision of this number is voluntary and providing or not providing the number will have no effect in any way on . . .'s benefits. This number will be useful in conducting future followup studies. This number will be used to match against the vital statistics records maintained by the National Center for Health Statistics. This information is collected under the authority of Section 306 of the Public Health Service Act.

6. What is . . .'s Social Security Number?

Social Security Number

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01 Refused
02 Don't know

7. What was the date of . . .'s most recent admission with your facility, that is, the date on which . . . was admitted for the current episode of care?

Month	Day	Year

8. Has . . . previously been a resident in this facility?

01 Yes
02 No

9a. According to . . .'s medical record, what were the primary and other diagnoses at the time of admission on (date in item 7)?

PROBE: Any other diagnoses?

Primary: 1 _____
Others: 2 _____
3 _____
4 _____
5 _____
6 _____

b. According to . . .'s medical record, what are . . .'s CURRENT primary and other diagnoses?

PROBE: Any other diagnoses?

00 Same as 9a
Primary: 1 _____
Others: 2 _____
3 _____
4 _____
5 _____
6 _____

10. What level of care is . . . currently receiving from your facility? Is it skilled care, intermediate care or residential care?

01 Skilled care
02 Intermediate care
03 Residential care

Notes

HAND FLASHCARD 3.

11. Which of these aids does . . . currently use?

Mark (X) all that apply.

PROBE: Any other aids?

- 00 No aids used
- 01 Eye glasses (including contact lenses)
- 02 Hearing aid
- 03 Transfer equipment
- 04 Wheelchair
- 05 Cane
- 06 Walker
- 07 Crutches
- 08 Brace (any type)
- 09 Oxygen
- 10 Commode
- 11 Other aids or devices - Specify z

12 Don't know

For items 12a-13b, refer to item 11.

12a. Does . . . have any difficulty in seeing (when wearing glasses)?

- 01 Yes
 - 02 No
 - 03 Not applicable (e.g., comatose)
 - 04 Don't know
- } SKIP to item 13a

HAND FLASHCARD 4.

b. Is . . . 's sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?

- 01 Partially impaired
- 02 Severely impaired
- 03 Completely lost, blind
- 04 Don't know

13a. Does . . . have any difficulty in hearing (when wearing a hearing aid)?

- 01 Yes
 - 02 No
 - 03 Not applicable (e.g., comatose)
 - 04 Don't know
- } SKIP to item 14a

HAND FLASHCARD 5.

b. Is . . . 's hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?

- 01 Partially impaired
- 02 Severely impaired
- 03 Completely lost, deaf
- 04 Don't know

14a. Does . . . have trouble biting or chewing any kinds of food, such as firm meats or apples?

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

b. Has . . . lost ALL of (his/her) upper permanent natural teeth?

- 01 Yes
- 02 No - SKIP to item 14d
- 03 Don't know

c. Does . . . have an upper denture or plate?

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

d. Has . . . lost ALL of (his/her) lower permanent natural teeth?

- 01 Yes
- 02 No - SKIP to item 14f
- 03 Don't know

<p>14e. Does . . . have a lower denture or plate?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p>									
<p><i>Ask only if item 14 c = Yes OR item 14e = Yes, otherwise skip to item 14h</i></p> <p>f. How often does . . . wear the dentures?</p>	<p>01 <input type="checkbox"/> All the time 02 <input type="checkbox"/> Usually 03 <input type="checkbox"/> About half the time 04 <input type="checkbox"/> Seldom 05 <input type="checkbox"/> Never – <i>SKIP to item 14h</i> 06 <input type="checkbox"/> Don't know</p>									
<p>g. Does . . . usually wear dentures when eating?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p>									
<p>h. How would you describe the condition of . . .'s teeth and gums; excellent, very good, good, fair or poor?</p> <p><i>If resident DOES NOT have any teeth then ask the following:</i></p> <p>How would you describe the condition of . . .'s gums or soft tissue; excellent, very good, good, fair or poor?</p>	<p>01 <input type="checkbox"/> Excellent 02 <input type="checkbox"/> Very good 03 <input type="checkbox"/> Good 04 <input type="checkbox"/> Fair 05 <input type="checkbox"/> Poor 06 <input type="checkbox"/> Don't know</p>									
<p>15a. Does . . . currently receive any assistance in bathing or showering?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 16a</i></p>									
<p>b. Does . . . bathe or shower with the help of:</p> <p>(1) Special equipment?</p> <p>(2) Another person?</p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>(1) Special equipment?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>(2) Another person?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> </table>		Yes	No	(1) Special equipment?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	(2) Another person?	01 <input type="checkbox"/>	02 <input type="checkbox"/>
	Yes	No								
(1) Special equipment?	01 <input type="checkbox"/>	02 <input type="checkbox"/>								
(2) Another person?	01 <input type="checkbox"/>	02 <input type="checkbox"/>								
<p>16a. Does . . . currently receive any assistance in dressing?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 17a</i></p>									
<p>b. Does . . . dress with the help of:</p> <p>(1) Special equipment?</p> <p>(2) Another person?</p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>(1) Special equipment?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>(2) Another person?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> </table>		Yes	No	(1) Special equipment?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	(2) Another person?	01 <input type="checkbox"/>	02 <input type="checkbox"/>
	Yes	No								
(1) Special equipment?	01 <input type="checkbox"/>	02 <input type="checkbox"/>								
(2) Another person?	01 <input type="checkbox"/>	02 <input type="checkbox"/>								
<p>17a. Does . . . currently receive any assistance in eating?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 18a</i></p>									
<p>b. Does . . . eat with the help of:</p> <p>(1) Special equipment?</p> <p>(2) Another person?</p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>(1) Special equipment?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>(2) Another person?</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> </table>		Yes	No	(1) Special equipment?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	(2) Another person?	01 <input type="checkbox"/>	02 <input type="checkbox"/>
	Yes	No								
(1) Special equipment?	01 <input type="checkbox"/>	02 <input type="checkbox"/>								
(2) Another person?	01 <input type="checkbox"/>	02 <input type="checkbox"/>								
<p>18a. Is . . . bedfast?</p>	<p>01 <input type="checkbox"/> Yes – <i>SKIP to item 22a</i> 02 <input type="checkbox"/> No</p>									
<p>b. Is . . . chairfast?</p>	<p>01 <input type="checkbox"/> Yes – <i>SKIP to item 22a</i> 02 <input type="checkbox"/> No</p>									

19a. Does . . . currently receive any assistance in transferring in and out of bed or a chair?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No } <i>SKIP to item 20a</i> 03 <input type="checkbox"/> Don't know
b. Does . . . require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
20a. Does . . . currently receive any assistance in walking?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 21a</i>
b. Does . . . walk with the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
21a. Does . . . go outside the grounds of this facility?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 22a</i>
b. When . . . goes outside the grounds, does . . . require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
22a. Does . . . have an ostomy, an indwelling catheter or similar device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 22c</i>
b. Does . . . receive any help from another person in caring for this device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
c. Does . . . currently receive any assistance using the toilet room?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 23</i> 03 <input type="checkbox"/> Does not use toilet room (ostomy patient, chairfast, etc.) – <i>SKIP to item 23</i>
d. Does . . . require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
23. Does . . . currently have any difficulty in controlling (his/her) bowels?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., infant, had a colostomy)
24. Does . . . currently have any difficulty in controlling (his/her) bladder?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)
Notes	

HAND FLASHCARD 6.

25. Does . . . currently receive personal help or supervision in any of the following activities:

a. Care of personal possessions?

Yes No

01 02

b. Managing money?

01 02

c. Securing personal items such as newspapers, toilet articles, snack food?

01 02

d. Using the telephone (dialing or receiving calls)?

01 02

26. During the past 12 months, has . . . had a flu shot at this facility or any other location?

01 Yes
02 No
03 Don't know

27. Has . . . EVER had a pneumococcal vaccine, that is, pneumonia vaccination?

01 Yes
02 No
03 Don't know

INSTRUCTION BOX

For questions 28, 30, 31, 32, and 33, use the phrase "LAST MONTH" if the resident was admitted last month or earlier. Use the phrase "SINCE ADMISSION" if the resident was admitted this month.

HAND FLASHCARD 7.

28. (Last month/since admission) which of these services were received by . . . , either inside or outside this facility?

Mark (X) all that apply.

PROBE: Any other services?

- 00 None
- 01 Dental care
- 02 Equipment or devices
- 03 Hospice services
- 04 Medical services
- 05 Mental health services
- 06 Nursing services
- 07 Nutritional services
- 08 Occupational therapy
- 09 Personal care
- 10 Physical therapy
- 11 Prescribed medicines or nonprescribed medicines
- 12 Sheltered employment
- 13 Social services
- 14 Special education
- 15 Speech or hearing therapy
- 16 Transportation
- 17 Vocational rehabilitation
- 18 Other – Specify _____

HAND FLASHCARD 8.

29. What was the PRIMARY source of payment for . . .'s care for the month of (Month and year of admission)?

Refer to item 7 on page 3.

Mark (X) only one source.

- 01 Private insurance
- 02 Own income, family support, Social Security benefits, retirement funds
- 03 Supplemental Security Income (SSI)
- 04 Medicare
- 05 Medicaid
- 06 Other government assistance or welfare
- 07 Religious organizations, foundations, agencies
- 08 VA contract, pensions, or other VA compensation
- 09 Payment source not yet determined
- 10 Other – Specify _____
- 11 Don't know

HAND FLASHCARD 8.

30. (Last month/since admission) what was the PRIMARY source of payment for ...'s care?

Mark (X) only one source.

- 01 Private insurance
- 02 Own income, family support, Social Security benefits, retirement funds
- 03 Supplemental Security Income (SSI)
- 04 Medicare
- 05 Medicaid
- 06 Other government assistance or welfare
- 07 Religious organizations, foundations, agencies
- 08 VA contract, pensions, or other VA compensation
- 09 Payment source not yet determined
- 10 Other - Specify

HAND FLASHCARD 8.

31. (Last month/since admission) what were all the secondary sources of payment for ...'s care?

Mark (X) all that apply.

- 00 None
- 01 Private insurance
- 02 Own income, family support, Social Security benefits, retirement funds
- 03 Supplemental Security Income (SSI)
- 04 Medicare
- 05 Medicaid
- 06 Other government assistance or welfare
- 07 Religious organizations, foundations, agencies
- 08 VA contract, pensions, or other VA compensation
- 09 Payment source not yet determined
- 10 Other - Specify

32. (Last month/since admission) what were the total charges billed for ...'s care, including all charges for services, drugs and special medical supplies?

\$ _____ . per

- 01 Month
- 02 Day
- 03 Week
- 04 Other period - Specify

Month	Day	Year	TO	Month	Day	Year

- 05 Not billed yet
- 00 No charge was made

HAND FLASHCARD 9.

33. (Last month/since admission) what was the primary source of payment for ...'s dental care?

Mark (X) only one source.

- 01 Own income, family support, Social Security benefits, retirement funds
- 02 Medicaid
- 03 VA contract, pension, or other VA compensation
- 04 Other government assistance or welfare
- 05 Covered in basic patient charges
- 06 Payment source not yet determined
- 07 No dental services received last month/since admission

FILL SECTION C ON THE COVER OF THIS FORM

Notes