




National Post-Acute and Long-Term Care Study 2020 Residential Care Community Questionnaire

Dear Administrator or Executive Director,

The Centers for Disease Control and Prevention conducts the National Post-Acute and Long-Term Care Study (formerly known as the National Study of Long-Term Care Providers or NSLTCP). Please complete this questionnaire about the residential care community at the location listed below.

- **Due to the COVID-19 pandemic, we understand services at this residential care community may be temporarily suspended, reduced, or offered through alternative methods. Although some questions may be difficult to answer at this time, please complete the survey to the best of your ability.**
- If this residential care community is associated with another residential care community or is part of a facility or campus that offers multiple levels of care, please answer only for the residential care community portion operating at the location on the label below.
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to <https://www.cdc.gov/nchs/npals/index.htm> or call 1-877-256-8171.

Label here

 Residential care places are known by different names in different states. We refer to all of these places and others like them as residential care communities.

Just a few terms used to refer to these places are assisted living, personal care, and adult care homes, facilities, and communities; adult family and board and care homes; adult foster care; homes for the aged; and housing with services establishments.

Thank you for taking the time to complete this questionnaire.

Notice – CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333; ATTN: PRA (0920-0943).

Assurance of Confidentiality – We take your privacy very seriously. All information that relates to or describes identifiable characteristics of individuals, a practice, or an establishment will be used only for statistical purposes. NCHS staff, contractors, and agents will not disclose or release responses in identifiable form without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42U.S.C. 242m) and the Confidential Information Protection and Statistical Efficiency Act (Title III of the Foundations for Evidence-Based Policymaking Act of 2018 (Pub. L. No. 115-435, 132 Stat. 5529 § 302)). In accordance with CIPSEA, every NCHS employee, contractor, and agent has taken an oath and is subject to a jail term of up to five years, a fine of up to \$250,000, or both if he or she willfully discloses ANY identifiable information about you.

Background Information

1. Is this residential care community located in the same building as, on the grounds of, or immediately adjacent to each of the following settings?
MARK YES OR NO IN EACH ROW

	Yes	No
a. Independent living residences	<input type="checkbox"/>	<input type="checkbox"/>
b. Hospital	<input type="checkbox"/>	<input type="checkbox"/>
c. Nursing home or skilled nursing facility	<input type="checkbox"/>	<input type="checkbox"/>
d. Home health agency	<input type="checkbox"/>	<input type="checkbox"/>
e. Hospice agency	<input type="checkbox"/>	<input type="checkbox"/>
f. Adult day services center	<input type="checkbox"/>	<input type="checkbox"/>
g. A specific unit where subacute or rehabilitation care is provided	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any item in question 1, please answer all questions only for the residential care community portion operating at the location on the cover page of this questionnaire.

2. What is the type of ownership of this residential care community? **MARK ONLY ONE ANSWER**

- Private—nonprofit
 Private—for profit
 Publicly traded company or limited liability company (LLC)
 Government—federal, state, county, or local

3. Is this residential care community currently licensed, registered, certified, or otherwise regulated by the State?

- Yes
 No → Skip to **question 43**

4. At this residential care community, what is the number of licensed, registered, or certified residential care beds? Include both occupied and unoccupied beds. If this residential care community is licensed, registered, or certified by apartment or unit, please count the number of single resident apartments or units as one bed each, two bedroom apartments or units as two beds each and so forth.

If none, enter "0."

Number of beds

→ If you answered fewer than 4 beds, skip to **question 43**

5. Is this residential care community permitted, licensed or regulated to only serve adults with an intellectual or developmental disability, severe mental illness, or both? Do not include Alzheimer's disease or other dementias. **MARK ONLY ONE ANSWER**

- Yes, **both** intellectual or developmental disability and severe mental illness **only**
 Yes, **only** intellectual or developmental disability
 Yes, **only** severe mental illness
 No, none of the above

→ Skip to **question 43**

6. Does this residential care community offer at least 2 meals a day to residents?

- Yes
 No → Skip to **question 43**

7. What is the total number of residents currently living in this residential care community? Include residents for whom a bed is being held while in the hospital. If you have respite care residents, please include them. If none, enter "0."

Number of residents

→ If you answered "0," skip to **question 43**

8. Does this residential care community provide or arrange for any of the following types of staff to be on-site 24 hours a day, 7 days a week to meet any resident needs that may arise? On-site means the staff are located in the same building, in an attached building or next door, or on the same campus.

MARK A RESPONSE IN EACH ROW

	Yes	On an as needed basis or on call	No
a. Personal care aide or staff caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Director, Assistant Director, Administrator or Operator (if they provide personal care or nursing services to residents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

→ If you answered "No" to 8a, 8b, and 8c, skip to **question 43**

9. Does this residential care community offer...

MARK YES OR NO IN EACH ROW

	Yes	No
a. help with activities of daily living (ADLs), such as help with bathing, either directly or arranged through an outside vendor?	<input type="checkbox"/>	<input type="checkbox"/>
b. assistance with medications, such as the administration of medications, give reminders, or provide central storage of medications?	<input type="checkbox"/>	<input type="checkbox"/>

→ If you answered "No" to both 9a and 9b, skip to question 43

10. Is this residential care community owned by a person, group, or organization that owns or manages two or more residential care communities? This may include a corporate chain.

- Yes
 No

11. Is this residential care community authorized or otherwise set up to participate in Medicaid?

- Yes
 No → Skip to question 13

12. During the last 30 days, for how many of the residents currently living in this residential care community did Medicaid pay for some or all of their services received at this community? If none, enter "0."

Number of residents

13. Does this residential care community only serve adults with dementia or Alzheimer's disease?

- Yes → Skip to question 17
 No

14. Does this residential care community have a distinct unit, wing, or floor that is designated as a dementia, Alzheimer's, or memory care unit?

- Yes
 No → skip to question 17

15. How many licensed beds are in the dementia, Alzheimer's, or memory care unit, wing, or floor? If this residential care community is licensed, registered, or certified by apartments or units, please count the number of single resident apartments or units as one bed each, two bedroom apartments or units as two beds each and so forth. If none, enter "0."

Number of beds

16. Does this dementia or Alzheimer's Special Care Unit have... **MARK YES OR NO IN EACH ROW**

	Yes	No
a. higher staff-to-resident ratios compared to other units?	<input type="checkbox"/>	<input type="checkbox"/>
b. specially trained staff for residents with dementia or Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>

17. An Electronic Health Record (EHR) is a computerized version of the resident's health and personal information used in the management of the resident's health care. Other than for accounting or billing purposes, does this residential care community use Electronic Health Records?

- Yes
 No

18. Does this residential care community's computerized system support electronic health information exchange with each of the following providers? Do not include faxing. **MARK YES OR NO IN EACH ROW**

	Yes	No
a. Physician	<input type="checkbox"/>	<input type="checkbox"/>
b. Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>
c. Hospital	<input type="checkbox"/>	<input type="checkbox"/>
d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility	<input type="checkbox"/>	<input type="checkbox"/>
e. Other long-term care provider	<input type="checkbox"/>	<input type="checkbox"/>

19. Does this residential care community typically maintain documentation of residents' advance directives or have documentation that an advance directive exists in resident files?

- Yes
 No → skip to question 21

20. Of the current residents, how many have documentation of an advance directive in their file? If none, enter "0."

Number of residents

21. Does this residential care community have the following infection control policies and practices? **MARK YES OR NO IN EACH ROW**

	Yes	No
a. Have a written Emergency Operations Plan that is specific to or includes pandemic response	<input type="checkbox"/>	<input type="checkbox"/>
b. Have a designated staff member or consultant responsible for coordinating the infection control program	<input type="checkbox"/>	<input type="checkbox"/>
c. Offer annual influenza vaccination to residents	<input type="checkbox"/>	<input type="checkbox"/>
d. Offer annual influenza vaccination to all employees or contract staff	<input type="checkbox"/>	<input type="checkbox"/>

Services Offered

22. Services currently offered by this residential care community can include services offered at this physical location or virtually (online or by telephone). For each service listed below... **MARK ALL THAT APPLY IN EACH ROW**

This residential care community...	Provides the service by paid residential care community employees	Arranges for the service to be provided by outside service providers	Refers residents or family to outside service providers	Temporarily does not provide, arrange, or refer for this service	Does not provide, arrange, or refer for this service
a. Hospice services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <u>Social work services</u> —provided by licensed social workers or persons with a bachelor’s or master’s degree in social work, and may include an array of services such as psychosocial assessment, individual or group counseling, support groups, and referral services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <u>Mental or behavioral health services</u> —target residents' mental, emotional, psychological, or psychiatric well-being and may include diagnosing, describing, evaluating, and treating mental conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. <u>Therapy services</u> —physical, occupational, or speech therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. <u>Pharmacy services</u> —including filling of or delivery of prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Dietary and nutritional services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. <u>Skilled nursing services</u> —must be performed by an RN, LPN or LVN and are medical in nature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Transportation services for <u>medical or dental appointments</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. *The Long-Term Care Ombudsman Program is an advocacy program that serves people living in long-term care facilities. The program works to resolve resident problems, and provides information to residents, their families and facility staff about resident rights, care and quality of life. During the last 12 months, how often did a Long-Term Care Ombudsman Program representative assist or visit this residential care community?* **MARK ONLY ONE ANSWER**

- At least once every three months
 - Less than once every three months
 - A representative assisted or visited, but unsure how often
 - A representative did not assist or visit in the last 12 months
 - Don't know if a representative assisted or visited in the last 12 months
- } → Skip to question 25

24. **During the last 12 months, what did the representative do for this residential care community?**
MARK YES OR NO IN EACH ROW

	Yes	No
a. Visited residents in-person	<input type="checkbox"/>	<input type="checkbox"/>
b. Contacted or interacted with residents remotely	<input type="checkbox"/>	<input type="checkbox"/>
c. Responded to resident complaints	<input type="checkbox"/>	<input type="checkbox"/>
d. Worked with resident or family councils—including attending meetings	<input type="checkbox"/>	<input type="checkbox"/>
e. Responded to staff requests for help with resident issues or resident advocacy	<input type="checkbox"/>	<input type="checkbox"/>
f. Provided information or education to staff on resident issues, such as resident rights, care or services	<input type="checkbox"/>	<input type="checkbox"/>
g. Recommended processes to improve resident rights, care or quality of life	<input type="checkbox"/>	<input type="checkbox"/>
h. Other	<input type="checkbox"/>	<input type="checkbox"/>

Resident Profile

25. Of the residents currently living in this residential care community, what is the sex breakdown? Enter "0" for any categories with no residents.

	Number of Residents
a. Male	<input type="text"/>
b. Female	<input type="text"/>
TOTAL	<input type="text"/>

NOTE: Total should be the same as the number of residents provided in question 7.

26. Of the residents currently living in this residential care community, what is the age breakdown? Enter "0" for any categories with no residents.

	Number of Residents
a. Under 65 years	<input type="text"/>
b. 65–74 years	<input type="text"/>
c. 75–84 years	<input type="text"/>
d. 85 years or older	<input type="text"/>
TOTAL	<input type="text"/>

NOTE: Total should be the same as the number of residents provided in question 7.

27. Of the residents currently living in this residential care community, what is the racial-ethnic breakdown? Count each resident only once. If a non-Hispanic resident falls under more than one category, please include them in the "Two or more races" category. Enter "0" for any categories with no residents.

	Number of Residents
a. Hispanic or Latino, of any race	<input type="text"/>
b. Two or more races, not Hispanic or Latino	<input type="text"/>
c. American Indian or Alaska Native, not Hispanic or Latino	<input type="text"/>
d. Asian, not Hispanic or Latino	<input type="text"/>
e. Black, not Hispanic or Latino	<input type="text"/>
f. Native Hawaiian or Other Pacific Islander, not Hispanic or Latino	<input type="text"/>
g. White, not Hispanic or Latino	<input type="text"/>
h. Some other category reported in this residential care community's system	<input type="text"/>
i. Not reported (race and ethnicity unknown)	<input type="text"/>
TOTAL	<input type="text"/>

NOTE: Total should be the same as the number of residents provided in question 7.

28. Of the residents currently living in this residential care community, about how many have been diagnosed with each of the following conditions? Enter "0" for any categories with no residents.

	Number of Residents
a. Alzheimer disease or other dementias	<input type="text"/>
b. Arthritis	<input type="text"/>
c. Asthma	<input type="text"/>
d. Chronic kidney disease	<input type="text"/>
e. COPD (chronic bronchitis or emphysema)	<input type="text"/>
f. Depression	<input type="text"/>
g. Diabetes	<input type="text"/>
h. Heart disease (for example, congestive heart failure, coronary or ischemic heart disease, heart attack, stroke)	<input type="text"/>
i. High blood pressure or hypertension	<input type="text"/>
j. Intellectual or developmental disability	<input type="text"/>
k. Osteoporosis	<input type="text"/>

29. For about how many of your current residents do you help store or manage their opioid pain medications? Include reminders to take the opioid pain medication or handing the opioid pain medication to the residents to take. Examples include morphine, hydrocodone, oxycodone, codeine, fentanyl, and methadone, and combination opioid pain medications like hydrocodone, oxycodone, and codeine with acetaminophen. *If none, enter "0."*

Number of residents

30. Assistance refers to needing any help or supervision from another person, or use of assistive devices. Of the residents currently living in this residential care community, about how many now need any assistance in each of the following activities? Enter "0" for any categories with no residents.

	Number of Residents
a. With transferring in and out of a bed or chair	<input type="text"/>
b. With eating, like cutting up food	<input type="text"/>
c. With dressing	<input type="text"/>
d. With bathing or showering	<input type="text"/>
e. With using the bathroom (toileting)	<input type="text"/>
f. With locomotion or walking—this includes using a cane, walker, or wheelchair and/or help from another person	<input type="text"/>

31. As best you know, of the residents currently living in this residential care community, about how many were treated in a hospital emergency department in the last 90 days? If none, enter "0."

Number of residents

32. As best you know, of the residents currently living in this residential care community, about how many were discharged from an overnight hospital stay in the last 90 days? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay. If none, enter "0."

Number of residents

33. As best you know, about how many of your current residents had a fall in the last 90 days? Include falls that occurred in your residential care community or off-site, whether or not the resident was injured, and whether or not anyone saw the resident fall or caught them. Please just count one fall per resident who fell, even if the resident fell more than one time. If one of your residents fell during the last 90 days, but is currently in the hospital or rehabilitation facility, please include that person in your count. If no residents had a fall, enter "0."

Number of residents

Staff Profile

34. An individual is considered an employee if the residential care community is required to issue a Form W-2 federal tax form on their behalf. For each staff type below, indicate how many full-time employees and part-time employees this community currently has. Include employees who work at this physical location or virtually (on-line or by telephone). Enter "0" for any categories with no employees.

	Number of Full-Time Employees	Number of Part-Time Employees
a. Registered nurses (RNs)	<input type="text"/>	<input type="text"/>
b. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs)	<input type="text"/>	<input type="text"/>
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides	<input type="text"/>	<input type="text"/>
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work	<input type="text"/>	<input type="text"/>
e. Activities directors or activities staff	<input type="text"/>	<input type="text"/>

35. Contract or agency staff refer to individuals or organization staff under contract with and working at this residential care community but are not directly employed by the community. Does this community have any nursing, aide, social work, or activities contract or agency staff? *Include contract staff who work at this physical location or virtually (on-line or by telephone).*

Yes

No → Skip to question 37

36. For each staff type below, indicate how many full-time contract or agency staff and part-time contract or agency staff this residential care community currently has. *Do not include individuals directly employed by this residential care community. Enter "0" for any categories with no contract or agency staff.*

	Number of Full-Time Contract or Agency Staff	Number of Part-Time Contract or Agency Staff
a. Registered nurses (RNs)	<input type="text"/>	<input type="text"/>
b. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs)	<input type="text"/>	<input type="text"/>
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides	<input type="text"/>	<input type="text"/>
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work	<input type="text"/>	<input type="text"/>
e. Activities directors or activities staff	<input type="text"/>	<input type="text"/>

Information on COVID-19

37. Since January 2020, how many coronavirus disease (COVID-19) cases did this residential care community have among residents and among employees or contract staff? *Include only presumptive positive and confirmed cases. Enter "0" if none or select don't know if you do not know the number.*

	COVID-19 cases		COVID-19 cases that resulted in a hospitalization		COVID-19 cases that resulted in death	
	<input type="text"/>	If 1 or more →	<input type="text"/>	Don't Know <input type="checkbox"/>	<input type="text"/>	Don't Know <input type="checkbox"/>
a. Residents	<input type="text"/>	If 1 or more →	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
b. Employees or contract staff	<input type="text"/>	If 1 or more →	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

38. Since January 2020, how many residents with presumptive positive or confirmed COVID-19 infection did this residential care community need to transfer to another residential care community? *If none, enter "0".*

Number of residents

39. Since January 2020, did this residential care community experience any of the following in your prevention, response, or management of COVID-19 infections? **MARK YES, NO, OR DON'T KNOW IN EACH ROW**

	Yes	No	Don't Know
a. Screening of residents daily for fever or respiratory symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Notifying all residents or families of a case in the residential care community within 24 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Use of telephonics or audio-only calls to assess, diagnose, monitor, or treat residents with presumptive positive or confirmed COVID-19 infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Use of telemedicine or telehealth (i.e., audio with video, web videoconference) to assess, diagnose, monitor, or treat residents with presumptive positive or confirmed COVID-19 infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Limiting of communal dining and recreational activities in common areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Since January 2020 to now, did this residential care community experience a shortage of the following personal protective equipment? **MARK YES, NO, OR DON'T KNOW FOR EACH TIME PERIOD**

	January 2020 to March 2020			April 2020 to June 2020			July 2020 to September 2020			October 2020 to now		
	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know
a. Eye protection, gloves, face masks, or isolation gowns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. N95 respirators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. Since January 2020, how many residents with presumptive positive COVID-19 infection was this residential care community not able to test due to shortages of test kits? **If none, enter "0".**

Number of residents

42. Since January 2020, did this residential care community impose restrictions on the following individuals from entering the building? **MARK NEVER, SOMETIMES, OFTEN, ALWAYS, OR DON'T KNOW IN EACH ROW**

	Never	Sometimes	Often	Always	Don't know
a. Family and relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Visitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Volunteers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Non-essential consultant personnel (e.g., barbers, delivery personnel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Contact Information

43. We would like to keep your name, telephone number, work e-mail address, and job title for possible future contact related to participation in current and future National Post-Acute and Long-Term Care Study (NPALS) waves. Your contact information will be kept confidential and will not be shared with anyone outside this project team.

PLEASE PRINT

Your name	First Name <input type="text"/>	Last Name <input type="text"/>
Your work telephone number, with extension	<input type="text"/> - <input type="text"/> - <input type="text"/>	Ext. <input type="text"/>
Your work e-mail address	<input type="text"/>	
Your job title	<input type="text"/>	

Please return your questionnaire in the enclosed return envelope or mail it to:

NPALS
 RTI International
 ATTN: Data Capture
 5265 Capital Boulevard
 Raleigh, NC 27690

Thank you for participating in the 2020 National Post-Acute and Long-Term Care Study.