

2009 Overview of Assisted Living Survey Resident Profile

This survey intends to quantify trends in the Assisted Living sector regarding the profile of residents.

Please have the Director of Nursing, Director of Health and Wellness, and/or person in charge of resident care complete this survey.

Please do **NOT** complete this survey if your property has been **open for less than 12 months**.

For each property filling out this survey, four (4) residents should be RANDOMLY SELECTED and their profile completed. To do this, alphabetize your residents, divide the list into four (4) and take the last person in each group. For example, if you have 60 residents, divide the alphabetized list into 4 groups of 15, and survey the 15th, 30th, 45th, and 60th resident.

The random nature of this survey is critical to the accuracy and quality of information. We understand that you may be asked to conduct a difficult survey for a resident with moderate to severe dementia through this random process. Please take the time to follow these guidelines. Thank you, in advance, for your cooperation.

If you are unsure of any answers, please feel free to leave your response blank.

It is recommended that the survey be completed on a paper copy first, as a partially complete survey cannot be saved online. To submit this survey online, please browse to:
http://www.surveymonkey.com/s.aspx?sm=LWe6cG_2bbC1SkqwnnDOu4aw_3d_3d

Thank you for your time in completing this survey!



DEMOGRAPHICS

- 1) Community Main Phone Number: _____
Zip Code of Property: _____
- 2) Age of Resident at Move-In _____ years _____ months
- 3) Current Age of Resident _____ years _____ months
- 4) Gender of Resident _____ Male _____ Female

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BACKGROUND ASSESSMENT

5) Resident's Prior PERMANENT Living Arrangement (please select one):

- Private home/apartment/rented room
- Family residence (lived with adult children or other relatives)
- Different residential care/assisted living/group home
- Retirement/independent living community
- Nursing home
- Other (please specify) _____

6) Distance Resident Relocated from Prior Permanent Living Arrangement

- Less than 5 miles
- 5 to 10 miles
- 11 to 25 miles
- 26 to 50 miles
- More than 50 miles

7) Did the Resident Transfer into the Property Immediately From a ... (please select one)

- Acute care hospital
- Rehabilitation hospital/unit
- Short stay nursing facility
- None of the above
- Other (please specify) _____

8) In the past 12 months, how recently has the resident

	Current Situation	Within Last Week	Within 8 to 14 days ago	Within last 15 to 30 days	Within last 12 months	Not Within last 12 months
Been treated in a hospital emergency room?						
Been a patient in a hospital overnight or longer?						
Had a short-term stay in a nursing home?						

9) Resident's Decision to Move In Was ...

- All Resident's Decision
- Partially Resident's Decision
- Another's Decision
- Do not know

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15) Family Involvement – Proximity of your Property to Resident's Closest Family Members

- ___ Less than 5 miles
- ___ 5 to 10 miles
- ___ 11 to 25 miles
- ___ 26 to 50 miles
- ___ More than 50 miles

16) Psychosocial well-being:

Over the last 30 days, how often did the resident receive one or more outside visitors?

- Daily
- At least several times a week
- About once a week
- At least once in the last 30 days
- None at all in the last 30 days
- Do not know

17) PHYSICAL FUNCTIONING – Normal Modes of Locomotion and Assistive Devices

	<u>Yes</u>	<u>No</u>
Walking, no assistive device	<input type="checkbox"/>	<input type="checkbox"/>
Walking, uses assistive device (e.g., cane, crutch, walker)	<input type="checkbox"/>	<input type="checkbox"/>
Some use of wheelchair/electric cart/scooter	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair/cart/scooter is MAIN mode of locomotion	<input type="checkbox"/>	<input type="checkbox"/>
Bedfast all or most of time	<input type="checkbox"/>	<input type="checkbox"/>

18) Normal ADL Self-Performance

Independent = virtually no help or oversight needed

Supervision = Oversight, encouragement, or cueing needed

Limited Assistance = Resident highly involved in activity; receives physical help in guided maneuvering of limbs or other non-weight-bearing help

Extensive Assistance = While resident performed part of activity, help of the following type(s) provided: weight-bearing support; full staff performance during part (but not all)

Total Dependence = Full staff performance of activity each time activity occurred

	<u>Performs Independently</u>	<u>Performs with Supervision</u>	<u>Limited Assistance</u>	<u>Extensive Assistance</u>	<u>Total Dependence</u>
Transfer (into or out of bed and/or chair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk within Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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19) Normal IADL Self-Performance

	Can Perform Independently	Can Perform with Supervision	Would Need Limited Assistance	Would Need Extensive Assistance	Would be Totally Dependent	N/A (Property Conducts This Activity)
Using the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare Meals, Snacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20) Change in ADL Status (compared to 90 days ago)

___ No change ___ Improved ___ Deteriorated

21) Continence

	<u>Generally continent</u>	<u>Not on consistent basis</u>	<u>Generally incontinent</u>
Bladder Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH STATUS

22) Does the Resident Have a Diagnosis of Alzheimer's or Another Form of Dementia?

___ Yes ___ No

23) If Yes, Please Check the Box that Best Describes the Diagnosis ...

- ___ Early-stage of Alzheimer's
- ___ Mid-stage of Alzheimer's
- ___ Late-stage of Alzheimer's
- ___ Mild other dementia
- ___ Severe other dementia

24) Does the Resident Live in a Dementia / Alzheimer's Special Care Unit?

___ Yes ___ No

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25) Has the Resident been *Diagnosed* with the Following Diseases?

	<u>Yes</u>	<u>No</u>
Arthritis or rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Coronary heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure / Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration / glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Other mental disorder (e.g., Bipolar, Schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS

26) How many different prescriptions does the resident receive in a given day? _____

27) How many different over-the-counter medications does the resident take daily?
_____ (estimate if necessary)

SERVICE PLANNING

28) Formal Services Used by Resident (within last 90 days)

	<u>Yes</u>	<u>No</u>
Hospice	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>
Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services (including substance abuse treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Adult day care	<input type="checkbox"/>	<input type="checkbox"/>
Podiatry	<input type="checkbox"/>	<input type="checkbox"/>
Home Healthcare Services	<input type="checkbox"/>	<input type="checkbox"/>
Companion Services / Sitters	<input type="checkbox"/>	<input type="checkbox"/>

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29) Questions for CARE GIVER

How long have you worked at this community? _____ Years _____ Months

What best describes your position at this community? *(Multiple responses allowed)*

- RN
- LPN
- Certified medication aide or supervisor
- Personal care aide / direct care staff
- Activity director
- Owner, administrator, director, or manager
- Other: _____

THANK YOU for filling out the survey.

If you have any questions, please contact Gary Byala at (703) 860-3355 x104 or E-mail:
gary@acclaropartners.com

To submit this paper survey, please send it to:

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