



**FISCAL YEAR 2005
STATE OF GEORGIA
ANNUAL NURSING HOME QUESTIONNAIRE**

INSTRUCTIONS AND DEFINITIONS

REVIEW INSTRUCTIONS AND DEFINITIONS BEFORE COMPLETING THE SURVEY

- IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

The Annual Nursing Home Questionnaire is being administered for all nursing homes operated in Georgia. You should have received an identification number for your facility that is required to complete the survey. Please retain a copy of the completed survey for your records. You may print a hard copy of the completed survey prior to submission for review.

Please respond to all questions. When a numerical answer is required, enter "0" (zero) if that is the correct response.

Data should be submitted for the entire Report Period or the last day of the Report Period as requested. If the nursing home was sold or leased during the Report Period, it is the responsibility of the **current nursing home operator** to obtain all necessary records from the previous operator(s) to complete this questionnaire.

Some totals must balance and agree with relevant totals in the questionnaire. If relevant totals do not balance and agree as appropriate, the survey instrument will prompt the respondent and will not allow submission of the questionnaire.

If you have any questions, please contact:

**Virginia Seery,
Division of Health Planning
Georgia Department of Community Health
404 656 0463
vseery@dch.state.ga.us**

PART A: GENERAL INFORMATION

1. **Respond as requested.** Please be sure to provide both the nursing home's Medicaid and Medicare provider numbers, but do not use alpha characters or dashes.
2. **Report Period:** July 1, 2004 through June 30, 2005 is the **required** report period. If the facility was in operation for a full year **you must** report data for a full year. If the ownership, operation or management of the facility changed during the report period, it is the responsibility of the **current owner or operating entity** to obtain the necessary data from the prior owner or operator.

PART B: CONTACT INFORMATION

Provide the name, title, and phone numbers of the person authorized to respond to inquiries about the responses to the survey. This person must retain a copy of the completed questionnaire.

PART C: OWNERSHIP, PROGRAMS & LICENSURE

If your facility submitted an Annual Nursing Home Questionnaire for 2004, the submitted 2004 information should be pre-loaded for your convenience. You are required to update the pre-loaded 2004 information with any changes occurring during the 2005 Report Period.

DEFINITIONS:

Facility Owner - refers to the person or entity that owns the building and grounds. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

Facility Operator - refers to the owner of the business accountable for the profits and losses. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

Management - refers to a specific entity that the Owner or Operator has contracted to manage the routine business. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

Lessee - refers to the entity that has rented the actual building in which the business is operated.

Sub-lessee - refers to the entity that has rented from the original lessee.

Changes - refers to any Owner or Operator changes that occurred during the report period **7/1/03 through 6/30/04** or after the last day of the Report Period. This should **NOT** reflect any change solely in administrators.

Other Health Care Facilities - refers to health care organizations such as but not limited to nursing homes, hospitals, home health agencies, ambulatory surgery centers, personal care homes, and hospices.

Organizational Affiliations - refers to your facility being affiliated with a retirement complex, a licensed personal care home, a hospital, or a hospice. Generally, such affiliations are indicated when the facilities are on the same campus and share the same administrative control.

Special Programs:

Alzheimer's Disease Program – planned and structured array of services and daily routines for persons with Alzheimer's Disease/Dementia.

Respite Care Program – an organized program that provides care and supervision to a dependent client to sustain the family or other primary care giver by providing that person with temporary relief from the ongoing responsibility of care.

Inpatient Hospice Program – an inpatient program of specialized palliative and supportive services from terminally ill persons and their families, including medical, psycho-social, volunteer and bereavement services.

Adult Day Care Program – a program that provides adults with personal care in a protective setting outside their own homes during a portion of a 24-hour day.

PART D: BEDS AND UTILIZATION

DEFINITIONS:

Beginning Census - the total number of patients in your facility on the last day of the previous Report Period, **6/30/04**.

Ending Census – the total number of patients in your facility on the last day of the current Report Period, **6/30/05**. This field is calculated by adding the net increase in patients (admissions minus discharges) to the Beginning Census.

Admission - the formal acceptance of a patient who is to receive inpatient services in the facility.

Discharge - the release of a patient from the facility, who was discharged to home, transferred to another institution, or died.

Beds Set Up and Staffed - all beds that are staffed with personnel including both occupied and unoccupied beds. Temporary changes in the number of beds due to renovations, painting, etc., do not affect bed count as reported here.

Number of total Medicare, Medicaid and Private and Other Patients - count the patients reported on the census of 6/30/2003 plus the new admissions from July 1, 2004 to June 30, 2005; then sort each patient by payment source. **Remember**, a patient may be included in more than one category.

Race/Ethnicity Categories: (as defined by the U.S. Census Bureau)

American Indian or Alaska Native - A person having racial origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having racial origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American – A person having racial origins in any of the Black racial groups of Africa.

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish Origin” can be used in addition to “Hispanic” or “Latino.”

Native Hawaiian or Other Pacific Islander – A person having racial origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White – A person having racial origins in any of the original peoples of Europe, the Middle East, or North Africa. Include people who indicate their race as “White” or report entries such as Irish, German, Lebanese, Near Easterner, Arab, or Polish.

Multi-Racial – A person having racial origins from two or more of the above definitions.

DIAGNOSTIC CATEGORIES:

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|-----------------------------------|--|
| Mental Retardation | ICD-9-CM DIAGNOSIS CODES 317-319 |
| Mental Illness/Psychoses | ICD-9-CM DIAGNOSIS CODES 290-316 |
| Alzheimer's Disease | ICD-9-CM DIAGNOSIS CODE 331.0 |
| HIV/AIDS | ICD-9-CM DIAGNOSIS CODES 042 and/or 079.53 |
| Severe Physical Disability | Persons with severe physical impairment and/or traumatic brain injury, which substantially limits one or more functional activities of daily living and require assistance of another individual |

PART E: FACILITY WORKFORCE INFORMATION:

The Division of Health Planning is collecting workforce information to support the State's workforce planning activities. The Division is currently focusing on planning efforts for Registered Nurses, Licensed Practical Nurses, Nurse Aides/Assistants, and other direct care staff. Please report the budgeted number of full-time staff (FTE) and the number of vacancies as of **June 30, 2005**.

Also, please report the average time your facility has spent during the past six months filling vacant positions. Use one of the four time periods provided for each professional category.

PART F: PATIENT ORIGIN:

Patient Origin – This represents the place where each patient was living prior to being admitted to your facility. This must reflect the Georgia County before he/she was admitted to your facility, or if the patient was from out-of-state, indicate where the patient was living prior to being admitted to your facility.

PART G: ELECTRONIC SIGNATURE AND CONTRACT

Please note that the survey **WILL NOT BE ACCEPTED** without the authorized signature of the **chief executive officer, executive director** or **principal administrator** of the facility pursuant to Rule 111-2-2-.04(1)(6). The typed version of this name will be accepted as the original signature of this authorized person pursuant to the Georgia Electronic Records and Signature Act. The signature can be completed only **AFTER** all survey data has been finalized. The signatory is attesting under penalty of law that the information is accurate and complete.