Purpose of the Study:

NORC at the University of Chicago, with funding from the Administration for Community Living/Administration on Aging (ACL/AoA), is conducting an evaluation of the Long-Term Care Ombudsman Program. The purpose of the survey is to better understand the relationships between the Long-Term Care Ombudsman Program and the facilities. This survey is voluntary and is not part of an audit or a compliance review. The information you provide is confidential. We do not include names of respondents in any reports or in any discussions with supervisors, colleagues, or ACL/AoA. This survey will take approximately ___ minutes to complete. Please complete and return this form using the pre-paid envelope, or by scanning and emailing it to LTCOPsurvey@norc.org, or by faxing it to 301-634-9582.

Please contact NORC at 1-877-XXX-XXXX or LTCOPsurvey@norc.org if you have any questions or concerns.

OMB Control No.: Expiration Date:

SECTION A: Activities and Interactions

1. How regularly does the Ombudsman visit your facility?
   
   __________________________

2. How does the Ombudsman spread awareness of the program among residents and their families?
   {Check all that apply}
   
   □ 1. Poster in the facility
   □ 2. Brochures and pamphlets in the facility
   □ 3. In-person interaction with residents throughout the facility
   □ 4. In-person interaction targeting new residents
   □ 5. Other (Please specify): ________________________________

3. Does your Ombudsman support or assist the development of resident and family councils in your facility?
   
   □ 1. Yes
   □ 2. No
   □ 97. Don’t know

4. Does the LTCOP participate in the licensing survey conducted by the state licensing and certification agency?
   
   □ 1. Yes
   □ 2. No
   □ 97. Don’t know
SECTION A: Activities and Interactions (continued)

5. Do you personally interact with the following Ombudsman Program representatives? {Check all that apply}

☐ 1. Ombudsman staff
☐ 2. Ombudsman volunteer
☐ 3. State Long-Term Care Ombudsman
☐ 4. Other LTCOP staff

Please note the position of these individuals: ______________________________________
_______________________________________________________________________
_______________________________________________________________________

6. What form does this interaction take? {Check all that apply}

☐ 1. In person
☐ 2. Phone call
☐ 3. Email
☐ 4. Other (please specify): ___________

7. On average how often do you personally interact with any of the representatives of the LTCOP?

☐ 1. Weekly
☐ 2. Monthly
☐ 3. Quarterly
☐ 4. Less than quarterly
☐ 5. As needed

8. What type of interaction have you had with Ombudsman representatives? {Check all that apply}

☐ 1. Discussion about facility compliance issue
☐ 2. Discussion about specific resident complaint
☐ 3. Discussion about pattern in resident complaints and potential solutions
☐ 4. Discussion about disagreement with a resident or resident’s family/friend
☐ 5. Discussion about potential training
☐ 6. Information provided

What was the topic? ______________________________________

☐ 7. Training provided by Ombudsman representative

What was the topic? ______________________________________

☐ 8. Other (please specify): ______________________________________
SECTION A: Activities and Interactions (continued)

9. Who at your facility interacts with the Ombudsman/Ombudsmen when they visit your facility? {Check all that apply}

☐ 1. Nurse practitioners (NPs)
☐ 2. Registered nurses (RNs)
☐ 3. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs)
☐ 4. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides
☐ 5. Social workers—licensed social workers or persons with a bachelor’s or master’s degree in social work
☐ 6. Activities director and activities staff _____________________
☐ 7. Other (please specify): _______________________________

10. Are there areas where you would like more support from the Ombudsman Program?

☐ 1. Yes
   If so, please describe: _______________________________
☐ 2. No

11. How could the Ombudsman Program be improved to better serve residents?

________________________________________________________________________

12. Based on your experience, what are the strengths of the Ombudsman Program?

________________________________________________________________________

13. Would you consider the relationship with your primary LTCOP contact to be:

☐ 1. Very effective
☐ 2. Somewhat effective
☐ 3. Somewhat ineffective
☐ 4. Not at all effective

14. Have you ever reported a complaint about an Ombudsman?

☐ 1. Yes
   If so, please describe the complaint: _______________________________
☐ 2. No
SECTION B: Program Outcomes
1. To your knowledge, has the Ombudsman Program contributed to changes in your facility’s policies and practices?
   □ 1. Yes
   □ 2. No
   □ 97. Don’t know

2. Do you agree with the following statement: Overall, residents benefit from Ombudsman presence in my facility?
   □ 1. Strongly agree
   □ 2. Agree
   □ 3. No opinion
   □ 4. Disagree
   □ 5. Strongly disagree

3. How effectively do Ombudsman resolve resident complaints in your facility?
   □ 1. Very effectively
   □ 2. Somewhat effectively
   □ 3. Not effectively
   □ 97. Don’t know

SECTION C: Background and Staff Profile
1. How many beds does your facility have?
   ____________________________

2. What is the type of ownership of this facility?
   □ 1. Private-nonprofit
   □ 2. Private-for profit
   □ 3. Publicly traded company or limited liability company (LLC)
   □ 4. Government—federal, state, county, or local

3. Is this facility owned by a person, group, or organization that owns or manages two or more long-term care facilities?
   □ 1. Yes
   □ 2. No
   □ 97. Don’t know

4. What is the total number of years this facility has been operating at this location?
   □ 1. Less than 1 year
   □ 2. 1 to 4 years
   □ 3. 5 to 9 years
   □ 4. 10 to 19 years
   □ 5. 20 or more years
SECTION C: Background and Staff Profile (continued)

5. For each staff type below, indicate how many full-time employees and part-time employees this facility currently has:

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Full-Time</th>
<th>Part-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Nurse practitioners (NPs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Registered nurses (RN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Social workers—licensed social workers or persons with a bachelor’s or master’s degree in social work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Activities director and activities staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU FOR COMPLETING THIS SURVEY.