RETURN SURVEY TO: Family Council Mailbox in Lobby by Nov. 15

WESTMINSTER NURSING HOME FAMILY COUNCIL
QUESTIONNAIRE FOR
FAMILY MEMBERS/FRIENDS

_____ _____
Your Name Resident's Name (optional)

1. How long have you been visiting the Westminster Nursing Home?

2. What do you like most about the Westminster Nursing Home?

3. Are you satisfied with the current visiting hours? If not, how would you like to see them changed?

4. Do you have specific times that you generally visit the nursing home? If so, please indicate (e.g., weekdays, evening, weekends).

5. Do you see a noted difference in the service provided on weekends vs. weekdays? Are the services less satisfactory or more satisfactory on the weekends? To what extent?

6. Has your family member/friend experienced any sickness or injury over the last year that developed while a resident at the nursing home (e.g., dehydration, incontinence, over medicated, infection, pneumonia, pressure sores, a fall)? Please explain.

7. Has your family member/friend been hospitalized for any of the condition(s) described above? Please explain.

8. Do you believe that your family member/friends abilities in activities of daily living have diminished significantly while living at the nursing home? If so, do you believe that it could have been avoidable? Please explain.

9. Do you believe that the overall care provided in the facility is improving, staying about the same or declining? Please explain.

10. Please list your major concerns (you may select from the list on the back of this page).

11. What suggestions do you have for improvements?

12. Additional comments (you may attach any documentation you wish):

(Continued on back)

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Unknown	N/A
Resident out of bed & dressed by reasonable time (10 a.m.)						
Accessibility of call button						
Timely response to call button						
Personal hygiene of residents						
Bathing						
Clean clothes						
Hair groomed						
Nails clean/trimmed						
Diapers changed promptly & properly cleaned						
Bedding changed when soiled						
Hands washed after toileting & before meals						
Bedpans removed & emptied promptly						
Toileting - if incontinent, checked every 2 hours						
Social activities provided to residents						
Amount of living space of resident						
Wheelchair accessibility of bathrooms						
Food selection (Provide specific comments below)						
Food service (Provide specific comments below)						
Ample feeding assistance						
Accessibility of water & other liquids						
Physical/Occupational Therapy (Medicare Only)						
Exercise/Ambulation (after Medicare) Non-PT/OT						
Room ventilation						
Cleanliness of facility						
Facility free of objectionable odors						
Laundry placed in proper container						
Laundry returned to resident						
Trash placed in proper container						
Staff coverage (weekdays)						
Staff coverage (weekends)						
Supervision of nursing assistants						
Overall Quality of Care						

Comments regarding food selections:

Comments regarding food service:

Other Comments: