**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance Page 1 of 4

F-62372 (11/2012)

**COMMUNITY BASED RESIDENTIAL FACILITY (CBRF)**

**RESIDENT SATISFACTION EVALUATION**

Wisconsin Administrative Code § DHS 83.35(4) requires that, at least **annually**, the CBRF shall provide the resident and the resident’s legal representative the opportunity to complete an evaluation of the resident’s level of satisfaction with the CBRF’s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department.

The resident satisfaction evaluation will be maintained in the resident record as required by § DHS 83.42(1)(i).

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| Name – Facility | | | | | | |
| Name – Resident | | | | Date – Form Completed | | |
| 1. All facilities must provide or make available to residents certain services. *From the following list, check the*  *services you receive:* | | | | | | |
| Supervision  Leisure time activities  Family contacts  Health monitoring  Medication monitoring/supervision  Help with personal care | Help in communication  Assistance in decision-making  Information and Referral  Activities in the community  Transportation | Access to medical services  Limited nursing services  Help with independent living skills  Opportunity to socialize with others  Transition services | | | | | |
| *List any other services you receive that are not included in the above list.* | | | | | | |
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| *List other services or activities that you feel you need but are* ***NOT*** *provided or arranged by the CBRF.* | | | | | | |
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| 1. Overall, I am satisfied with the services provided by this facility.   Yes  Somewhat  No  Don’t Know Comments: | | | | | | |
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| 1. The care I receive is the kind of care I desire.   Yes  Somewhat  No  Don’t Know Comments: | | | | | | |
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| 1. The facility meets my treatment preferences (choice of doctors, pharmacy, etc.)   Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 5. The facility meets my preferences for services (I receive the services I need or want).  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
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| 6. The facility offers a variety of activities for me to choose from.  Yes  Somewhat  No  Don’t Know *List activities in which you participate and how often.* | | | | | | |
|  | | | | | | |
| *List any activities you would like to have but which are not available.* | | | | | | |
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| 7. There appears to be enough staff on duty at all times to meet my needs as well as those of other residents.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 8. Staff members appear to know what their responsibilities are.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 9. I am treated respectfully at all times.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 10. My rights have been explained to me.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 11. I feel that my rights are being protected.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 12. The food served … | | | | | | |
| ... **is of good quality**  Yes  No  Don’t Know | | | | | | |
| Comments: | | | | | | |
| ... **meets my nutritional needs**   Yes  No  Don’t Know | | | | | | |
| Comments: | | | | | | |
| ... **is prepared well**   Yes  No  Don’t Know | | | | | | |
| Comments: | | | | | | |
| ... **tastes good**   Yes  No  Don’t Know | | | | | | |
| Comments: | | | | | | |
| ... **is always enough**   Yes  No  Don’t Know | | | | | | |
| Comments: | | | | | | |
| ... **is of a wide variety**   Yes  No  Don’t Know Know | | | | | | |
| Comments: | | | | | | |
| ... **hot foods are served hot and cold foods are served cold**  Yes  No  Don’t Know | | | | | | |
| Comments: | | | | | | |
| 13. My room is comfortable and meets my needs.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 14. The furnishings in my room are kept in good repair.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 15. My room, as well as the rest of the facility, is kept neat and clean.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 16. I feel safe and comfortable here.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 17. People respect my privacy.  Yes  Somewhat  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 18. The facility manages my personal funds.  Yes  No  Don’t Know | | | | | | |
| If you answered “Yes,” do you have concerns about how the facility is handling your funds? | | | | | | |
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| 19. The facility gives me **WRITTEN** notices of any changes in fees or services at least 30 days before the change happens.  Yes  No  Don’t Know *Comments:* | | | | | | |
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| 20. Do you control and take your own medications?  Yes  No  Don’t Know | | | | | | |
| **If you answered “NO,”** have either you or your doctor signed a paper allowing the facility to control your medications and give them to you?  Yes  No  Don’t Know *Comments:* | | | | | | |
|  | | | | | | |
| 21. If the facility assists me with my medications, I receive them … | | | | | | |
| ... **on time**   Yes  No  Don’t Know  Not Applicable | | | | | | |
| Comments: | | | | | | |
| ... **in an acceptable manner**  Yes  No  Don’t Know  Not Applicable | | | | | | |
| Comments: | | | | | | |
|  | | | | | | |
| ... **as prescribed by my doctor**  Yes  No  Don’t Know  Not Applicable | | | | | | |
| Comments: | | | | | | |
| 22. Any other comments regarding this facility you would like to make? *(Attach extra pages, if needed.)* | | | | | | |
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| **SIGNATURE –** Resident | | | Date Signed | | | |
| **SIGNATURE** – Guardian / Representative Assisting Completion of this Evaluation | | | Date Signed | | | |
| **SIGNATURE** – CBRF Staff Assisting Completion of this Evaluation | | | Date Signed | | | |
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