**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).

|  |
| --- |
| 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.*  |
|        |
|  *List other services or activities that you feel you need but are* ***NOT*** *provided or arranged by the CBRF.* |
|        |
| 1. Overall, I am satisfied with the services provided by this facility.

[ ]  Yes [ ]  Somewhat [ ]  No [ ]  Don’t Know Comments: |
|        |
| 1. The care I receive is the kind of care I desire.

[ ]  Yes [ ]  Somewhat [ ]  No [ ]  Don’t Know Comments: |
|        |
| 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:* |
|        |
| 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.*  |
|        |
| 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?  |
|        |
| 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:* |
|        |
| 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.)* |
|        |
| **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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