QUALITY SCALE SURVEY

ABC HEALTHCARE OF AMERICA, LLC
Individual:
Family Member:

For each item identified below, circle the number
to the right that best fits your judgment of its quality.
Use the scale above to select the quality number.

Description/Identification of Survey Item	**Scale** **Poor**		**Good**		**Excellent**
1. Do you believe that your family member is safe?	1	2	3	4	5
2. Are the needs of your family member being met?	1	2	3	4	5
3. Is your family member integrated into the community?	1	2	3	4	5
4. Are the surroundings safe and comfortable?	1	2	3	4	5
5. Is your family member given a choice?	1	2	3	4	5
6. Is the staff sensitive to your family member's need?	1	2	3	4	5
7. Do you feel safe around the staff member?	1	2	3	4	5
8. Does the staff member respect your family member's rights?	1	2	3	4	5
9. Would you recommend us to a family member or friend?	1	2	3	4	5
10. How would you rate our overall service?	1	2	3	4	5

Please post your personal comments and concerns regarding our services below.

____ ___________ ________________________
PRINT NAME/SIGNATURE **DATE**

We appreciate your feedback in helping us provide excellent service to our residents. Please mail the survey to us in the attached envelope. The Management and Staff of **ABC Healthcare of America, LLC** appreciate your feedback.