

STAFF INTERVIEW

Facility Name: _____ Facility ID: _____ Date: _____ Time: _____

Surveyor Name: _____ Staff Name: _____

| Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|

A Catheter Use QP079

1) Is there use of an indwelling foley catheter?

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) | <input type="checkbox"/> No (Skip to B) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |

2) What is the reason for the resident's catheter? **(The diagnosis of neurogenic bladder must be verified in the medical record) (Mark all that apply)**

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction | <input type="checkbox"/> A: Obstruction |
| <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder | <input type="checkbox"/> B: Neurogenic / atonic bladder |
| <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer | <input type="checkbox"/> C: Stage III or IV perineal / sacral pressure ulcer |
| <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness | <input type="checkbox"/> D: Terminal illness |
| <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment | <input type="checkbox"/> E: Mobility impairment |
| <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma | <input type="checkbox"/> F: Coma |
| <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request | <input type="checkbox"/> G: Resident request |
| <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence | <input type="checkbox"/> H: Incontinence |
| <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown | <input type="checkbox"/> I: Unknown |
| <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ | <input type="checkbox"/> J: Other, describe _____ _____ |

STAFF INTERVIEW

| | | | | | | | | | |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|

B Nutrition QP082

1) Is this resident receiving a nutritional supplement, defined as a prescribed high protein, high calorie, nutritional supplement between or with meals? **(There must be documentation in the medical record.)**
Following discussion with staff about whether a resident receives a supplement, request documentation of a recording and monitoring system to support a 'Yes' answer. This documentation may include a checkbox or checklist that the supplement was given, a percentage of supplement consumed or the amount consumed. Any of these methods are acceptable. The following sources may provide supporting documentation:

- Medication Administration Record
- Treatment Record
- Snack/Supplement List
- Meal documentation with supplements listed separately
- Other source(s) as indicated by facility staff

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, resident receives tube feedings/ NPO |
|---|--|--|--|--|--|--|--|--|---|

C Skin Care/Pressure Ulcers QP049 QP050

1) Does the resident currently have one or more pressure ulcers? If yes, indicate the stage of the most advanced pressure ulcer.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|
| <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 | <input type="checkbox"/> No pressure ulcers <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 |
|--|--|--|--|--|--|--|--|--|---|

STAGE I - A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

STAGE II - A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

STAGE III - A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

STAGE IV - A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

STAFF INTERVIEW

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: | Resident: |
| D Side Rails QP093 | | | | | | | | | |
| 1) Are side rails (includes half or quarter rails) used for this resident? | | | | | | | | | |
| <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes |
| 2) Is the resident physically capable of getting out of bed on his or her own? | | | | | | | | | |
| <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to E) <input type="checkbox"/> Yes |
| 3) When the rails are raised, do they prevent the resident from voluntarily getting out of bed? | | | | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| E Contractures QP264 | | | | | | | | | |
| 1) Does the resident have a contracture? (Defined as a condition of fixed high resistance to passive stretch of a muscle.) | | | | | | | | | |
| <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes | <input type="checkbox"/> No (Skip to F) <input type="checkbox"/> Yes |
| 2) Does the resident receive range of motion services or have a splint device in place? | | | | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| F Falls & Fractures QP265 | | | | | | | | | |
| 1) Has the resident had a fall and/or sustained a fracture within the last 30 days? | | | | | | | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes |