

**STAFF INTERVIEW**

Facility Name: \_\_\_\_\_ Facility ID: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Surveyor Name: \_\_\_\_\_ Staff Name: \_\_\_\_\_

Resident:									
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**A Catheter Use** QP079

1) Is there use of an indwelling foley catheter?

<input type="checkbox"/> No (Skip to B)									
<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"/> 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"/> E: Mobility impairment									
<input type="checkbox"/> F: Coma									
<input type="checkbox"/> G: Resident request									
<input type="checkbox"/> H: Incontinence									
<input type="checkbox"/> I: Unknown									
<input type="checkbox"/> J: Other, describe _____ _____									

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Resident:									
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**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
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**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
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**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:
<b>D Side Rails QP093</b>									
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
<b>E Contractures QP264</b>									
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
<b>F Falls &amp; Fractures QP265</b>									
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