

**STAFF INTERVIEW**

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

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

Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	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"/> 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)**

a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction	a) Obstruction
b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder	b) Neurogenic / atonic bladder
c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer	c) Stage III or IV perineal / sacral pressure ulcer
d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness	d) Terminal illness
e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment	e) Mobility impairment
f) Coma	f) Coma	f) Coma	f) Coma	f) Coma	f) Coma	f) Coma	f) Coma	f) Coma	f) Coma
g) Resident request	g) Resident request	g) Resident request	g) Resident request	g) Resident request	g) Resident request	g) Resident request	g) Resident request	g) Resident request	g) Resident request
h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence	h) Incontinence
i) Unknown	i) Unknown	i) Unknown	i) Unknown	i) Unknown	i) Unknown	i) Unknown	i) Unknown	i) Unknown	i) Unknown
j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____	j) Other, describe: _____ _____

### STAFF INTERVIEW

Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	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, the surveyor is guided to 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, provide a percentage of supplement consumed or list the amount consumed. Any of these methods are acceptable. The following sources may provide supporting documentation:

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

<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<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
<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<input type="checkbox"/> N/A, resident receives tube feedings/ NPO	<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 ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer	<input type="checkbox"/> No ulcer
<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I	<input type="checkbox"/> Stage I
<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2	<input type="checkbox"/> Stage 2
<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3	<input type="checkbox"/> Stage 3
<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<input type="checkbox"/> Stage 4	<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:
<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 and 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