

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)**

<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:
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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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STAFF INTERVIEW

Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:	Resident:
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C Skin Care/Pressure Ulcers QP049 QP050

1) Does the resident currently have one or more pressure ulcers? If yes, describe the most advanced stage for each pressure ulcer when they were at their deepest visible anatomical level.

<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers	<input type="checkbox"/> No pressure ulcers
<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 1
<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
<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)	<input type="checkbox"/> Unstageable (eschar/slough)
<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury	<input type="checkbox"/> Suspected Deep Tissue Injury

Staff should answer the question based on the most advanced stage of each existing ulcer. Staff should not “reverse” stage. To describe a healing wound, it is more accurate not to reclassify it at a lower stage, but rather to use the historically deepest stage and prefix this with the term “healing.” A Stage 4 pressure ulcer that is almost healed is designated a “healing Stage 4” and not “downstaged” to a Stage 3, 2, or 1. If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.

- Stage 1** – Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
- Stage 2** – Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.
- Stage 3** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- Stage 4** – Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
- Unstageable** – Pressure ulcer is known but not stageable due to non-removable dressing/device or due to the coverage of the wound bed by slough or eschar.
- Suspected Deep Tissue Injury (sDTI)** – Suspected deep tissue injury in evolution. Localized area of discolored (darker than surrounding tissue) intact skin or blood-filled blister related to damage of underlying soft tissue from pressure and/or shear. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

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