

RESIDENT INTERVIEW & RESIDENT OBSERVATION

Facility Name: _____ Facility ID: _____ Date: _____

Surveyor Name: _____

Resident Name: _____ Resident ID: _____ Admit Date: _____ Resident Room: _____

Resident Interview

Ask screening questions similar to the following:

1. Are you from around here, the area, etc?
2. Tell me a little about yourself.
3. How long have you been here?
4. What is the food like here?

Proceed with the interview questions below if you are comfortable that the resident is interviewable.

A Cognitive Status

1) Is the resident able to be interviewed?

- Not Interviewable
- Interviewable
- Resident refused interview
- Resident is unavailable for an interview

If the resident is interviewable, proceed to the Resident Interview section on the following page. If the resident is not interviewable, refuses, or is unavailable (after repeated attempts to interview) proceed to the Resident Observation section on the following page (the resident is excluded from the resident interview).

Notes:

RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
B Choices QP234	
1) Do you choose when to get up in the morning? If No: What time do you get up? What time would you like to get up in the morning?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, the resident is independent with ADLs
2) Do you choose when to go to bed at night? If No: What time do you go to bed? What time would you like to go to bed?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, the resident is independent with ADLs
3) Do you choose how many times a week you take a bath or shower? If No: How many times a week do you get a bath or shower? How many times a week would you like to bathe?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, the resident is independent with ADLs
4) Do you choose whether you take a shower, tub, or bed bath? If No: What type of bathing are you receiving? What would you like to receive?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, the resident is independent with ADLs
5) Can you have visitors anytime during the day or night? If No: What are the visiting restrictions?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:	
C Dignity QP212	
1) Do staff treat you with respect and dignity? If No, Tell me some examples about when staff did not treat you with respect and dignity. The focus of this question is how well staff interacts with the resident.	<input type="checkbox"/> No <input type="checkbox"/> Yes

Resident Observation	
A Cleanliness/Grooming/Oral QP075 (excluding A1E)	
1) Based on general observations, did you see any of the following? (Mark all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> A: Unpleasant body odor (other than signs of incontinence) <input type="checkbox"/> B: Skin unclean (i.e., food on face and hands) <input type="checkbox"/> C: Eyes are matted <input type="checkbox"/> D: Mouth contains debris, or teeth/dentures not brushed, or mouth odor, or dentures not in place <input type="checkbox"/> E: Teeth broken/loose, or inflamed/bleeding gums, or problems with dentures QP216 <input type="checkbox"/> F: Hair is uncombed and not clean <input type="checkbox"/> G: Facial hair not removed or unshaven <input type="checkbox"/> H: Fingernails are unclean and untrimmed <input type="checkbox"/> I: Clothing and/or linens are soiled (other than signs of incontinence) <input type="checkbox"/> J: Glasses are dirty or broken <input type="checkbox"/> K: None of the above 	
B Incontinence QP260	
1) Are there signs of incontinence, such as odor and/or wetness?	<input type="checkbox"/> No <input type="checkbox"/> Yes
C Dressing QP074	
1) Based on general observations, did you see any of the following? (Mark all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> A: Clothing in poor repair, improper fit, or worn inappropriately <input type="checkbox"/> B: Inappropriate foot coverings (i.e., shoes without non-skid soles) <input type="checkbox"/> C: None of the above 	
Comments:	

RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
D Activities QP208	
1) Do you participate in the activity programs here? If "No", ask why he/she doesn't participate.	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Does not wish to participate (Skip to 4)
2) Do the activities meet your interests?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Are the activities provided as often as you would like, including on weekends and evenings?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4) Does staff provide items so you can do activities on your own, like books or cards?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, family provides
Comments:	
E Building and Environment	
1) Is the building clean?	<input type="checkbox"/> No QP201 <input type="checkbox"/> Yes
2) Do you have any problems with the temperature, lighting, noise or anything else in the building that affects your comfort? (Mark all that apply)	<input type="checkbox"/> Temperature QP272 <input type="checkbox"/> Lighting QP273 <input type="checkbox"/> Noise QP274 <input type="checkbox"/> Other identified issues QP275 <input type="checkbox"/> None of the above
Comments:	
F Participation in Care Plan QP210	
1) Have you been involved in decisions about your daily care?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Resident Observation	
D Activities QP096	
(Complete for residents who are not interviewable due to cognitive screening. Do not complete for residents who are interviewable, have refused to be interviewed, or are unavailable.)	
1) Did you observe the resident in activities during the two days of Stage 1? (This is not limited to group activities or scheduled activities.)	<input type="checkbox"/> No (skip to E) <input type="checkbox"/> Yes
2) Is the resident actively participating in the activities or does staff encourage the resident to participate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments	
E Contractures QP077 QP076	
1) Does the resident have a contracture? (Defined as a condition of fixed high resistance to passive stretch of a muscle.) <i>If unable to determine ask staff member.</i>	<input type="checkbox"/> No (skip to F) <input type="checkbox"/> Yes
2) Does the resident have splint devices in place? (Answer "No" if device not present or is incorrectly applied.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:	

RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
G Abuse QP253	
1) Has staff, a resident or anyone else here abused you – this includes verbal, physical or sexual abuse? If “Yes,” ask who the abuser was, what happened, when it occurred, where it happened, and how often.	<input type="checkbox"/> No (skip to 3) <input type="checkbox"/> Yes
2) Did you tell staff? If “Yes,” ask who the resident told. If “No,” report immediately to the administrator. If you have concerns with how the facility handles the investigation after you report it, consider initiating abuse.	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Have you seen any resident here being abused? If “Yes,” ask who the abuser was, what happened, when it occurred, where it happened, and how often.	<input type="checkbox"/> No (skip to H) <input type="checkbox"/> Yes
4) Did you tell staff? If “Yes,” ask who the resident told. If “No,” report immediately to the administrator. If you have concerns with how the facility handles the investigation after you report it, consider initiating abuse.	<input type="checkbox"/> No <input type="checkbox"/> Yes
H Interaction with Others QP246	
1) Have there been any concerns or problems with a roommate or any other resident?	<input type="checkbox"/> No (skip to I) <input type="checkbox"/> Yes
2) Has the staff addressed the concern(s) to your satisfaction?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Resident Observation	
F Abuse QP205	
1) Is the resident being treated by staff, other residents, or anyone else at the facility in a way that may indicate physical, sexual, mental, or emotional abuse?	<input type="checkbox"/> No <input type="checkbox"/> Yes
G Skin Problems/Conditions (other than pressure ulcers) QP261	
1) Were any of the following observed? (Mark all that apply) <input type="checkbox"/> A: Abrasions and/or lacerations <input type="checkbox"/> B: Bruises <input type="checkbox"/> C: Skin Tears <input type="checkbox"/> D: Burns <input type="checkbox"/> E: None of the above	
H Potential Restraints QP092 QP089	
1) Does the resident have a potential restraint in place (physical device or equipment that may potentially restrict a resident’s movement and/or access to her/his body)?	<input type="checkbox"/> No (skip to I) <input type="checkbox"/> Yes
2) Which potential restraints are being used? (Mark all that apply) <input type="checkbox"/> A: Potential limb restraint <input type="checkbox"/> B: Potential trunk restraint <input type="checkbox"/> C: Chair potentially prevents rising <input type="checkbox"/> D: Bed side rails <input type="checkbox"/> E: Other (e.g., mittens), please describe _____	
3) Is the device correctly applied? (Such as potential trunk and limb restraints. See Section L below for bed side rails.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	

RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
I Personal Property QP194	
1) Were you encouraged by staff to bring in any personal items? If No: Do you wish to have items brought in?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, the resident is a short-stay resident
2) Have you had any missing personal items? If Yes: What is still missing and how long has it been missing?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Did you tell staff about the missing item(s)? If Yes: Who did you tell about the missing item? If the answer is "Yes," then ask question 4.	<input type="checkbox"/> No <input type="checkbox"/> Yes
4) Has staff told you they are looking for your missing item(s)? If No, do you know who or which department is supposed to be looking for your missing item?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:	
J Pain QP255	
1) Do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:	

Resident Observation	
I Pain QP129	
1) Were any of the following observed? (Mark all that apply)	
<input type="checkbox"/> A: Vocalization of pain: constant muttering, moaning, groaning <input type="checkbox"/> B: Breathing: strenuous, labored, negative noise on inhalation or expiration <input type="checkbox"/> C: Pained facial expressions: clenched jaw, troubled or distorted face, crying <input type="checkbox"/> D: Body language: clenched fists, wringing hands, strained and inflexible position, rocking <input type="checkbox"/> E: Movement: restless, guarding, altered gait, forceful touching or rubbing body parts <input type="checkbox"/> F: None of the above	
Comments:	
J Hydration QP182	
1) Does the resident demonstrate physical signs of dehydration (i.e., dry, cracked lips and/or dry mouth; exhibits signs of thirst, etc.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:	

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Resident Interview	
K Food Quality QP249	
1) Does the food taste good and look appetizing?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2) Is the food served at the proper temperature?	<input type="checkbox"/> No <input type="checkbox"/> Yes
L Hydration QP258	
1) Do you receive the fluids you want between meals?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, does not take fluids orally
Comments:	
M Sufficient Staff QP232	
1) Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Resident Observation	
K Positioning QP233	
1) Were any of the following observed? (Mark all that apply)	
<input type="checkbox"/> A: Sagging mattress while lying in bed <input type="checkbox"/> B: Bed sheets tucked tightly over toes holding the feet in plantar flexion <input type="checkbox"/> C: Legs and/or feet hanging off the end of a too-short mattress <input type="checkbox"/> D: No padding between bony prominences (residents not able to position themselves) <input type="checkbox"/> E: Wheelchair too big or too small (i.e., seat too long/short, seat too high/low) <input type="checkbox"/> F: Uncomfortable geri-chair positioning, hyperflexion of the neck, sliding down in the chair, no-support for the legs <input type="checkbox"/> G: Dangling legs and feet (that do not comfortably reach floor and/or without needed foot pedals in place) <input type="checkbox"/> H: Leaning to the side without support to maintain an upright position <input type="checkbox"/> I: Lack of needed head or torso support <input type="checkbox"/> J: Lack of arm/shoulder support <input type="checkbox"/> K: Resident observed in the same position for long periods of time when in the wheelchair or in bed (Resident is not repositioned in chair at least every hour and in bed at least every two hours) <input type="checkbox"/> L: None of the above	
Comments:	
L Potential Accident Hazards/Bed Side Rails QP218	
1) If the bed side rails are in the up position, do the bed side rails fit the bed properly to prevent the resident from being caught between the side rails and mattress?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, side rails are not observed in the up position
Comments:	

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Resident Interview	
N Oral Health QP254 QP256	
1) Do you have mouth/facial pain with no relief?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2) Do you have any chewing or eating problems (could be due to: no teeth, missing teeth, oral lesions, broken or loose teeth)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Do you have tooth problems, gum problems, mouth sores, or denture problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4) Does staff help you as necessary to clean your teeth?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, do not need assistance (Skip to O)
5) How often are your teeth/dentures/mouth cleaned (routine oral hygiene)?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Never
O Privacy QP204	
1) Does staff provide you privacy when they work with you, changing your clothes, providing treatment?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2) Do you have privacy when on the telephone?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A, do not use telephone
3) If you would have a visitor, do you have a private place to meet?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments: 	

Resident Observation
M Resident's Room
1) Were any of the following observed? (Mark all that apply) <input type="checkbox"/> A: Odor in resident's room QP221 <input type="checkbox"/> B: Walls, floors, ceilings, drapes, or furniture are not clean or are in disrepair QP222 <input type="checkbox"/> C: Environment does not accommodate individual needs and preferences QP147 <input type="checkbox"/> D: Lighting levels are inadequate or uncomfortable QP223 <input type="checkbox"/> E: Room temperatures are uncomfortable or unsafe QP224 <input type="checkbox"/> F: Sound levels are uncomfortable QP225 <input type="checkbox"/> G: Bedrooms are not equipped to assure full privacy (i.e., curtains, moveable screens, private rooms, etc.) QP151 <input type="checkbox"/> H: Clean bed/bath linens are not available or are in poor condition QP152 <input type="checkbox"/> I: Evidence of insects or rodents in bedrooms or bathrooms QP226 <input type="checkbox"/> J: None of the above
Comments:
2) Were any of the following observed? (Mark all that apply) <input type="checkbox"/> A: Electric cords, extension cords, or outlets are in disrepair or used in an unsafe manner QP228 <input type="checkbox"/> B: Bed and linens are visibly soiled with stool or urine QP260 <input type="checkbox"/> C: Resident care equipment is unclean, in disrepair or stored in an improper or unsanitary manner QP140 <input type="checkbox"/> D: Ambulation, transfer or therapy equipment are unclean or in unsatisfactory condition QP229 <input type="checkbox"/> E: Safety equipment in bedroom or bathroom is inadequate (i.e. grab bars, slip surface) QP230 <input type="checkbox"/> F: Call system in room or bathroom is not functioning. QP231 <input type="checkbox"/> G: Call light not within reach for residents capable of using it QP267 <input type="checkbox"/> H: Accessible chemicals or other hazards in bedroom or bathroom QP268 <input type="checkbox"/> I: Unsafe hot water in room QP269 <input type="checkbox"/> J: Hot water is too cool QP270 <input type="checkbox"/> K: Room not homelike QP271 <input type="checkbox"/> L: None of the above
Comments:

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Resident Interview	
P Exercise of Rights QP250	
1) Have you been moved to a different room or had a roommate change in the last nine months?	<input type="checkbox"/> No (Skip to Q) <input type="checkbox"/> Yes
2) Were you given notice before a room change or a change in roommate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Q Personal Funds QP199	
1) Do you have a personal funds account with the facility?	<input type="checkbox"/> No (Skip #2 & 3) <input type="checkbox"/> Yes <input type="checkbox"/> Do Not Know (Skip #2 & 3)
2) Does the facility let you know how much money you have in your account?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do Not Know
3) Can you get your money when you need it, including on weekends?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do Not Know

Resident Observation	
N Dignity QP266	
1) Based on general observation, did you see any of the following? (Mark all that apply)	
<input type="checkbox"/> A: Staff dressed resident in institutional fashion such as a hospital type gown during the day <input type="checkbox"/> B: Clothes labeled with the resident's name visible <input type="checkbox"/> C: Staff failed to knock and/or request permission to enter the room or wait to receive permission to enter <input type="checkbox"/> D: Staff failed to explain the service or care they are going to provide <input type="checkbox"/> E: Staff failed to include the resident in conversations while providing care or services <input type="checkbox"/> F: Staff used a label for the resident (e.g., "feeder" or "honey") <input type="checkbox"/> G: Staff posted confidential clinical or personal care instructions in areas that can be seen by others <input type="checkbox"/> H: Staff failed to treat the resident respectfully when providing care to the resident's roommate; <input type="checkbox"/> I: Staff failed to treat the resident with respect and dignity during care and services, such as: <ul style="list-style-type: none"> • Making disapproving comments as "What do you want now?" • Mimicking or making fun of the resident • Displaying disapproving behavior (rolling their eyes, or sighing) <input type="checkbox"/> J: Staff failed to provide visual privacy of the resident's body while transporting him/her through common areas, or uncovered in their rooms but visible to others <input type="checkbox"/> K: Staff failed to cover a urinary catheter bag or any other type of body fluid collection device <input type="checkbox"/> L: Staff failed to respond to the resident's call for assistance in a timely manner <input type="checkbox"/> M: Any other identified dignity concerns (document concerns) <input type="checkbox"/> N: None of the above	
O Sedation	
1) Is the resident excessively sedated?	<input type="checkbox"/> No <input type="checkbox"/> Yes