

## RESIDENT INTERVIEW & RESIDENT OBSERVATION

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

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

Resident Name: \_\_\_\_\_ Resident ID: \_\_\_\_\_ Admit Date: \_\_\_\_\_ Resident Room: \_\_\_\_\_

### Resident Interview

**Suggested approaches for initiating a discussion:**

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>B Choices QP234</b>	
1) Are you able to participate in making decisions regarding food choices/ preferences?	<input type="checkbox"/> No <input type="checkbox"/> Yes ( <b>skip to #3</b> )
2) Is this acceptable to you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Do you participate in choosing your bedtime?	<input type="checkbox"/> No <input type="checkbox"/> Yes ( <b>skip to #5</b> )
4) Is this acceptable to you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5) Do you participate in choosing when to get up?	<input type="checkbox"/> No <input type="checkbox"/> Yes ( <b>skip to #7</b> )
6) Is this acceptable to you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7) Do you choose your dressing and bath schedule?	<input type="checkbox"/> No <input type="checkbox"/> Yes ( <b>skip to C</b> )
8) Is this acceptable to you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Comments:</b>	
<b>C Dignity QP212</b>	
1) Do you feel the staff treats you with respect and dignity? For example, does staff take the time to listen to you and are staff helpful when you request assistance? (The focus of this question is how well staff interacts with the resident.)	<input type="checkbox"/> No <input type="checkbox"/> Yes

Resident Observation	
<b>A Cleanliness/Grooming/Oral QP075 QP216</b>	
1) <b>Based on general observations, did you see any of the following?</b> (Mark all that apply) <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 <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>Comments:</b>	
<b>B Incontinence QP260</b>	
1) Are there signs of incontinence, such as odor and/or wetness?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>C Dressing QP074</b>	
1) <b>Based on general observations, did you see any of the following?</b> (Mark all that apply) <input type="checkbox"/> A: Inappropriate clothing for time of day and season <input type="checkbox"/> B: Clothing in poor repair, improper fit, or worn inappropriately <input type="checkbox"/> C: Inappropriate foot coverings (i.e., shoes without non-skid soles) <input type="checkbox"/> D: None of the above	
<b>Comments:</b>	

## RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
<b>D Activities QP208</b>	
1) Do you participate in any of the activity programs here?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do not wish to participate
2) Do the organized activities meet your interests?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Do you receive assistance for things you like to do, such as supplies, batteries, books? (Facility should have items available for residents to use.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
4) Are there activities offered on the weekends, including religious events?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5) Are there activities available in the evenings?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Comments:</b>	
<b>E Building and Environment QP201</b>	
1) Is this a comfortable building in which to live? (Comfortable includes appropriate temperature, lighting, and noise levels.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
2) Is the facility clean?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Comments:</b>	
<b>F Participation in Care Plan QP210</b>	
1) Have you been involved in decisions about your daily care?	<input type="checkbox"/> No <input type="checkbox"/> Yes <b>(skip to G)</b>

Resident Observation	
<b>D Activities QP096</b>	
<b>(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.)</b>	
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 <b>(skip to E)</b> <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
<b>Comments</b>	
<b>E Contractures QP077 QP076</b>	
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 <b>(skip to F)</b> <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
<b>Comments:</b>	

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Resident Interview	
<b>G Abuse QP253</b>	
1) Have you ever been treated roughly by staff?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2) Has staff yelled or been rude to you?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3) Do you ever feel afraid because of the way you or some other resident is treated?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If surveyor suspects potential abuse based on the above responses, ask who, what, when, where, how often?	
<b>H Interaction with Others QP246</b>	
1) Have there been any concerns or problems with a roommate or any other resident?	<input type="checkbox"/> No ( <b>skip to I</b> ) <input type="checkbox"/> Yes
2) Has the staff addressed the concern(s) to your satisfaction?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>I Personal Property QP194</b>	
1) Have you had any missing personal items, such as clothing, jewelry, a radio, money, etc? <b>If Yes:</b> Can you tell me what is missing and for how long? Do you have any idea of what might have happened to the item(s)?	<input type="checkbox"/> No ( <b>skip to J</b> ) <input type="checkbox"/> Yes
2) Did you report the missing property to staff?	<input type="checkbox"/> No ( <b>skip to J</b> ) <input type="checkbox"/> Yes
3) Is the property still missing?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Comments:</b>	

Resident Observation	
<b>F Abuse QP205</b>	
1) Are staff treating the resident in a manner that may indicate abuse (yelling at resident, striking resident, treating resident in a rough manner, etc.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>G Skin Problems/Conditions (other than pressure ulcers) QP261</b>	
1) <b>Were any of the following observed?</b> (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	
<b>H Potential Restraints QP092 QP089</b>	
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 ( <b>skip to I</b> ) <input type="checkbox"/> Yes
2) <b>Which potential restraints are being used?</b> (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 (excludes beds with only one ¼ rail that is on the side of the bed against the wall) <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
<b>Comments:</b>	

## RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
<b>J Pain QP255</b>	
1) Do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief?  <b>Comments:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>K Food Quality QP249</b>	
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
<b>L Hydration QP258</b>	
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
<b>Comments:</b>	

Resident Observation	
<b>I Pain QP129</b>	
1) <b>Were any of the following observed?</b> (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	
<b>Comments:</b>	
<b>J Hydration QP182</b>	
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
<b>Comments:</b>	

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Resident Interview	
<b>M Sufficient Staff</b> 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
<b>N Oral Health</b> 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 <b>(Skip to O)</b>
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
<b>O Privacy</b> 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
<b>Comments:</b>	

Resident Observation	
<b>K Positioning</b> QP233	
<b>1) Were any of the following observed?</b> (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	
<b>Comments:</b>	
<b>L Potential Accident Hazards/Bed Side Rails</b> QP218	
<b>1)</b> 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
<b>Comments:</b>	

## RESIDENT INTERVIEW & RESIDENT OBSERVATION

Resident Interview	
<b>P Exercise of Rights QP250</b>	
1) Have you been moved to a different room or had a roommate change in the last nine months?	<input type="checkbox"/> No ( <b>Skip to Q</b> ) <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
<b>Q Personal Funds QP199</b>	
1) Do you have a personal funds account with the facility?	<input type="checkbox"/> No ( <b>Skip #2 &amp; 3</b> ) <input type="checkbox"/> Yes <input type="checkbox"/> Do Not Know ( <b>Skip #2 &amp; 3</b> )
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

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