Conduct the Staff Interview with the direct-care RN or LPN for the resident.

A. Catheter Use

1. Is there use of an indwelling foley catheter? 
   - No (skip to B)
   - Yes

   Comments:

a. 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.)

   - Obstruction
   - Neurogenic/ atonic bladder
   - Stage 3 or 4 perineal/sacral pressure ulcer
   - Terminal illness
   - Mobility impairment
   - Coma
   - Resident request
   - Incontinence
   - Unknown
   - Other (specify in comments):

   Comments:

B. Pressure Ulcers

1. Does the resident currently have one or more pressure ulcers? 
   - No (skip to C)
   - Yes

   Comments:
a. Describe the most advanced stage for each pressure ulcer when they were at their deepest visible anatomical level.

- **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 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.

Comments:
C. Side Rails

1. Are side rails (including half or quarter rails) used for this resident?
   - No (skip to D)
   - Yes

Comments:

a. Is the resident physically capable of getting out of bed on his or her own?
   - No (skip to D)
   - Yes

Comments:

b. When the rails are raised, do they prevent the resident from voluntarily getting out of bed?
   - No
   - Yes

Comments:

D. Contractures

1. Does the resident have a contracture? (Defined as a condition of fixed high resistance to passive stretch of a muscle.)
   - No (skip to E)
   - Yes

Comments:

a. Does the resident receive range of motion services or have a splint device in place?
   - No
   - Yes

Comments:
E. Falls and Fractures

1. How many falls has the resident had in the last 30 days?
   - None (interview is complete)
   - 1 fall
   - 2 or more falls

   Comments:

   a. Did any fall result in an injury?

   Comments: