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|  | Attachment G  **Assisted Living Facility Resident Interview** | | | | |
| ASSISTED LIVING FACILITY NAME | | | | LICENSE NUMBER | |
| INSPECTION DATE | | LICENSOR NAME | | | CD ID NUMBER |
|  | | | | | |
| RESIDENT NAME | | | RESIDENT NUMBER | ROOM NUMBER | PAY STATUS  Private  State |
| REPRESENTATIVE NAME | | | | REPRESENTATIVE PHONE NUMBER | |
| Brief Review of Negotiated Service Agreement: | | | | | |
| Water Temperature (required for half of sampled residents): Not reviewed for sample resident:  Temperature:  Date:Time: AM /  PM | | | | | |
|  | | | | | |
| INTERVIEW TYPE  Resident Interview  Representative Interview Date:Time: AM /  PM | | | | | |
| 1. The following are **REQUIRED** questionsand **MUST** be asked during the interview. Check “Y,” if the answer is yes; check “N,” if the answer is no and document the interviewee’s response; or check “D” if the interviewee declined to answer the question. If the question does not apply to the resident, indicate N/A | | | | | |
| Y N D N/A  Can you make choices about the care and services you receive here at the facility? | | | | | |
| If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to? | | | | | |
| Do you have an opportunity to participate in community activities? | | | | | |
| Can you choose who visits you and when? | | | | | |
| Do they pay attention to what you have to say? | | | | | |
| Can you choose to lock your door? | | | | | |
| Do you have access to food anytime? | | | | | |
| Do you receive services in the community? | | | | | |
| See Page 2 for Section B through K. | | | | | |

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| **Instructions:** Each category **must** be addressed, using the sample question(s) or your own. Check the box by the question(s) asked, document the answers, and investigate further if there are concerns. Check the “no concerns” box when no concerns are identified (any additional notes are optional). | |
| 1. **Care and Service Needs**  **No Concerns** | |
| What does the staff help you with?  Do you receive help with medications? Who helps you:  Other: | |
| 1. **Support of Personal Relationships (if the resident has family or significant others)  No Concerns** | |
| Are you able to meet with visitors when you wish or make phone calls in private? | |
| Other: | |
| 1. **Reasonable House Rules  No Concerns** | |
| Are there any rules that prevent you from doing the things you like to do every day? | |
| Other: | |
| 1. **Respect of Individuality, Independence, Personal Choice, Dignity  No Concerns** | |
| Are you allowed to make choices? Are staff respectful of your choices? | |
| How do staff treat you and speak to you? | |
| Do staff call you by your preferred name? | |
| Other: | |
| 1. **Sense of Well-Being and Safety  No Concerns** | |
| Do you feel safe here? | |
| Has anyone ever yelled at you or made you feel afraid? | |
| Other: | |
| 1. **Response to Concerns  No Concerns** | |
| Who would you talk to if you had concerns about your care? | |
| Other: | |
| 1. **Homelike Environment  No Concerns** | |
| Tell me about your room. Did you help decorate it? | |
| Other: | |
| 1. **Meals / Snacks / Preferences  No Concerns** | |
| Do you eat your meals in the dining room? | |
| Have you lost weight since you admitted to the facility? | |
| Other: | |
| 1. **Activities  No Concerns** | |
| Do you attend activities? Tell me more. | |
| Other: | |
| 1. **Notice  No Concerns** | |
| Have you ever had any issues with your billing? | |
| Has anyone talked to you about Medicaid? | |
| Other: | |
| 1. **Notes  No Concerns** | |
|  | |
| Leave a contact number for the resident to be able to contact you / RCS staff in the future. |