§483.15 Quality of Life
A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.

Interpretive Guidelines §483.15
The intention of the quality of life requirements is to specify the facility’s responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident. Compliance decisions here are driven by the quality of life each resident experiences.

§483.15(a) - Dignity
The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.

Interpretive Guidelines: §483.15(a)

“Dignity” means that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. Some examples include (but are not limited to):

- Grooming residents as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped);

- Encouraging and assisting residents to dress in their own clothes appropriate to the time of day and individual preferences rather than hospital-type gowns;

- Assisting residents to attend activities of their own choosing;

- Labeling each resident’s clothing in a way that respects his or her dignity (e.g., placing labeling on the inside of shoes and clothing);

- Promoting resident independence and dignity in dining such as avoidance of:
  - Day-to-day use of plastic cutlery and paper/plastic dishware;
  - Bibs (also known as clothing protectors) instead of napkins (except by resident choice);
  - Staff standing over residents while assisting them to eat;
  - Staff interacting/conversing only with each other rather than with residents while assisting residents;
- Respecting residents’ private space and property (e.g., not changing radio or television station without resident’s permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident’s personal possessions without permission);

- Respecting residents by speaking respectfully, addressing the resident with a name of the resident’s choice, avoiding use of labels for residents such as “feeders,” not excluding residents from conversations or discussing residents in community settings in which others can overhear private information;

- Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services;

- Maintaining an environment in which there are no signs posted in residents’ rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status). It is allowable to post signs with this type of information in more private locations such as the inside of a closet or in staff locations that are not viewable by the public. An exception can be made in an individual case if a resident or responsible family member insists on the posting of care information at the bedside (e.g., do not take blood pressure in right arm). This does not prohibit the display of resident names on their doors nor does it prohibit display of resident memorabilia and/or biographical information in or outside their rooms with their consent or the consent of the responsible party if the resident is unable to give consent. (This restriction does not include the CDC isolation precaution transmission-based signage for reasons of public health protection, as long as the sign does not reveal the type of infection);

- Grooming residents as they wish to be groomed (e.g., removal of facial hair for women, maintaining the resident’s personal preferences regarding hair length/style, facial hair for men, and clothing style).

**NOTE:** For issues of failure to keep dependent residents’ faces, hands, fingernails, hair, and clothing clean, refer to Activities of Daily Living (ADLs), Tag F312;

- Maintaining resident privacy of body including keeping residents sufficiently covered, such as with a robe, while being taken to areas outside their room, such as the bathing area (one method of ensuring resident privacy and dignity is to transport residents while they are dressed and assist them to dress and undress in the bathing room).

**NOTE:** For issues of lack of visual privacy for a resident while that resident is receiving ADL care from staff in the bedroom, bathroom, or bathing room, refer to §483.10(e), Privacy and Confidentiality, Tag F164. Use Dignity F241 for issues of visual privacy while residents are being transported through common areas or are uncovered in their rooms and in view of others when not receiving care; and

- Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a resident’s request for toileting assistance during meal times, and restricting residents from use of common areas open to the general public such as
lobbies and restrooms, unless they are on transmission-based isolation precautions or are restricted according to their care planned needs. An exception can be made for certain restrooms that are not equipped with call cords for safety.

**Procedures: §483.15(a)**

For a sampled resident, use resident and family interviews as well as information from the Resident Assessment Instrument (RAI) to consider the resident’s former lifestyle and personal choices made while in the facility to obtain a picture of the resident’s individual needs and preferences.

Throughout the survey, observe: Do staff show respect for residents? When staff interact with a resident, do staff pay attention to the resident as an individual? Do staff respond in a timely manner to the resident’s requests for assistance? Do they explain to the resident what care they are doing or where they are taking the resident? Do staff groom residents as they wish to be groomed?

In group activities, do staff members focus attention on the group of residents? Or, do staff members appear distracted when they interact with residents? For example, do they continue to talk with each other while doing a “task” for a resident(s) as if the resident were not present?

Are residents restricted from using common areas open to the public such as the lobby or common area restrooms? If so, determine if the particular area is restricted to the resident for the resident’s safety. For example, does the restroom lack a call cord for safety? If so, that restroom may be restricted from resident use. Are there signs regarding care information posted in view in residents’ rooms? If these are observed, determine if such signs are there by resident or family direction. If so, these signs are allowable. If a particular resident has been restricted from common areas by the care team, confer with staff to determine the reason for the restriction.

Do staff members communicate personal information about residents in a way that protects the confidentiality of the information and the dignity of residents? This includes both verbal and written communications such as signage in resident rooms and lists of residents with certain conditions such as incontinence and pressure ulcers (or verbal staff reports of these confidential matters) at nursing stations in view or in hearing of residents and visitors. This does not include clinical information written in a resident’s record.

Determine if staff members respond in a dignified manner to residents with cognitive impairments, such as not contradicting what residents are saying, and addressing what residents are trying to express (the agenda) behind their behavior. For example, a resident with dementia may be attempting to exit the building in the afternoon, but the actual intent is a desire to meet her children at the school bus, as she did when a young mother. Allowing the behavior under supervision such as walking with the resident without challenging or disputing the resident’s intent and conversing with the resident about the desire (tell me about your children) may assist the behavior to dissipate, and the staff member can then invite the resident to come along to have a drink or snack or participate in a task or activity. For more information about “agenda” behavior, see Rader, J., Tornquist, E, Individualized Dementia Care: Creative, Compassionate
If the survey team identifies potential compliance issues regarding the privacy of residents during treatment, refer to §483.10(e), Privacy and Confidentiality, Tag F164.

§483.15(b) - Self-Determination and Participation
The resident has the right to--

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

Intent: §483.15(b)
The intent of this requirement is to specify that the facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. This includes actively seeking information from the resident regarding significant interests and preferences in order to provide necessary assistance to help residents fulfill their choices over aspects of their lives in the facility.

Interpretive Guidelines: §483.15(b)
Many types of choices are mentioned in this regulatory requirement. The first of these is choice over “activities.” It is an important right for a resident to have choices to participate in preferred activities, whether they are part of the formal activities program or self-directed. However, the regulation at §483.15(f) Activities, F248 covers both formal and self-directed activities. For issues concerning choices over activities, use Tag F248.

The second listed choice is “schedules.” Residents have the right to have a choice over their schedules, consistent with their interests, assessments and plans of care. Choice over “schedules” includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking, eating, bathing, and the time for going to bed at night. Residents have the right to choose health care schedules consistent with their interests and preferences, and the facility should gather this information in order to be proactive in assisting residents to fulfill their choices. For example, if a resident mentions that her therapy is scheduled at the time of her favorite television program, the facility should accommodate the resident to the extent that it can. If the resident refuses a bath because he or she prefers a shower or a different bathing method such as in-bed bathing, prefers it at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the staff
member should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstance provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her preferences.

**NOTE:** For issues regarding choice over arrangement of furniture and adaptations to the resident’s bedroom and bathroom, see §483.15(e)(1), Accommodation of Needs, Tag F246. According to this requirement at §483.15(b)(3), residents have the right to make choices about aspects of their lives that are significant to them. One example includes the right to choose to room with a person of the resident’s choice if both parties are residents of the facility, and both consent to the choice.

If a facility changes its policy to prohibit smoking, it must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. Weather permitting; this may be an outside area. Residents admitted after the facility changes its policy must be informed of this policy at admission. (See §483.10(b)(1)).

**Procedures: §483.15(b)**

During resident and family interviews, determine if the resident is able to exercise her/his choices regarding personal activities, including whether the facility provides assistance as needed to the resident to be able to engage in their preferred activities on a routine basis.

During resident and family interviews, determine what time the resident awakens and goes to sleep, and whether this is the resident’s preferred time. Also determine whether the facility is honoring the resident’s preferences regarding the timing (morning, afternoon, evening and how many times a week) for bathing and also the method (shower, bath, in-bed bathing). Obtain further information as necessary from observations and staff interviews. If the resident is unaware of the right to make such choices, determine whether the facility has actively sought information from the resident and/or family (for a resident unable to express choices) regarding preferences and whether these choices have been made known to caregivers.

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**F243**

**§483.15(c) Participation in Resident and Family Groups**

(1) A resident has the right to organize and participate in resident groups in the facility;

(2) A resident’s family has the right to meet in the facility with the families of other residents in the facility;

(3) The facility must provide a resident or family group, if one exists, with private space;

(4) Staff or visitors may attend meetings at the group’s invitation;
The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

SEE INTERPRETIVE GUIDANCE FOR §483.15(c) AT TAG F244

§483.15(c)(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

Interpretive Guidelines §483.15(c)

This requirement does not require that residents’ organize a residents or family group. However, whenever residents or their families wish to organize, facilities must allow them to do so without interference. The facility must provide the group with space, privacy for meetings, and staff support. Normally, the designated staff person responsible for assistance and liaison between the group and the facility’s administration and any other staff members attend the meeting only if requested.

• “A resident’s or family group” is defined as a group that meets regularly to:

  o Discuss and offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life;

  o Support each other;

  o Plan resident and family activities;

  o Participate in educational activities; or

  o For any other purpose.

The facility is required to listen to resident and family group recommendations and grievances.

Acting upon these issues does not mean that the facility must accede to all group recommendations, but the facility must seriously consider the group’s recommendations and must attempt to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility should communicate its decisions to the resident and/or family group.

Procedures §483.15(c)

If no organized group exists, determine if residents have attempted to form one and have been unsuccessful, and, if so, why.
§483.15(d) Participation in Other Activities

A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

Interpretive Guidelines §483.15(d)

The facility, to the extent possible, should accommodate an individual’s needs and choices for how he/she spends time, both inside and outside the facility.

Ask the social worker or other appropriate staff how they help residents pursue activities outside the facility.

§483.15(e) - Accommodation of Needs

A resident has the right to --

§483.15(e)(1) - Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

Interpretive Guidelines: §483.15(e)(1)

“Reasonable accommodations of individual needs and preferences,” means the facility’s efforts to individualize the resident’s physical environment. This includes the physical environment of the resident’s bedroom and bathroom, as well as individualizing as much as feasible the facility’s common living areas. The facility’s physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident’s own needs and preferences.

NOTE: For issues regarding the psychosocial environment experienced by the resident, such as being ignored by staff, being made to feel unwelcome or that their care needs are burdensome to staff, refer to §483.15(a), Tag F241, Dignity.

The facility is responsible for evaluating each resident’s unique needs and preferences and ensuring that the environment accommodates the resident to the extent reasonable and does not endanger the health or safety of individuals or other residents. This includes making adaptations of the resident’s bedroom and bathroom furniture and fixtures, as necessary to ensure that the resident can (if able):

• Open and close drawers and turn faucets on and off;
• See her/himself in a mirror and have toiletry articles easily within reach while using the sink;
• Open and close bedroom and bathroom doors, easily access areas of their room and bath, and operate room lighting;
• Use bathroom facilities as independently as possible with access to assistive devices (such as grab bars within reach) if needed; and
• Perform other desired tasks such as turning a table light on and off, using the call bell; etc.

NOTE: If a resident cannot reach her/his clothing in the closet, if the resident does not have private closet space, or if the resident does not have needed furniture (such as a chair) refer to §483.15(h)(4) and §483.70(d)(2)(iv), Tag F461.

The facility should strive to provide reasonably sufficient electric outlets to accommodate the resident’s need to safely use her/his electronic personal items, as long as caution is maintained to not overload circuits. The bedroom should include comfortable seating for the resident and task lighting that is sufficient and appropriate for the resident’s chosen activities. The facility should accommodate the resident’s preferences for arrangement of furniture to the extent space allows, including facilitating resident choice about where to place their bed in their room (as long as the roommate, if any, concurs). There may be some limitations on furniture arrangement, such as not placing a bed over a heat register, or not placing a bed far from the call cord so as to make it unreachable from the bedside.

The facility should also ensure that furniture and fixtures in common areas frequented by residents are accommodating of physical limitations of residents. Furnishings in common areas should enhance residents’ abilities to maintain their independence, such as being able to arise from living room furniture. The facility should provide seating with appropriate seat height, depth, firmness, and with arms that assist residents to arise to a standing position. One method of accommodating residents of different heights and differing types of needs in common areas is through the use of different sizes and types of furniture.

NOTE: If residents are prohibited from using common area restrooms, the lobby, or dining rooms outside of meal times, refer to §483.15(a), Tag F241, Dignity.

For issues of sufficient lighting, refer to §483.15(h)(5), Tag F256, Adequate and Comfortable Lighting.

Staff should strive to reasonably accommodate the resident’s needs and preferences as the resident makes use of the physical environment. This includes ensuring that items the resident needs to use are available and accessible to encourage confidence and independence (such as grooming supplies reachable near the bathroom sink), needed adaptive equipment (such as door handle grippers) are maintained in place, and functional furniture is arranged to accommodate the resident’s needs and preferences, etc. This does not apply to residents who need extensive staff assistance and are incapable of using these room adaptations.
Staff should interact with the resident in a way that takes into account the physical limitations of the resident, assures communication, and maintains respect; for example, getting down to eye level with a resident who is sitting, speaking so a resident with limited hearing who reads lips can see their mouth when they speak, utilizing a hearing amplification device such as a pocket-talker if the resident has such a device, etc. Residents who use glasses, hearing aids, or similar devices should have them in use (except when the resident refuses), clean, and functional.

Procedures: §483.15(e)(1)

Observe the resident using her/his room and common areas and interview the resident if possible to determine if the environment has been adapted as necessary to accommodate the resident’s needs and preferences, as described above. Observe staff/resident interactions to determine if staff members adapt their interactions so that a resident with limited sight or hearing can see and hear them. Are hearing aids and glasses in use, clean, and functional? Determine if staff keep needed items within the resident’s reach and provide necessary assistance (set up) to help maintain the resident’s independent use of their environment to the maximum extent possible for the resident. Determine if the resident has the call system within reach and is able to use it if desired. (This does not include a resident who is too severely impaired to comprehend or is comatose.) Some residents need adaptations for limited hand dexterity or other physical limitations, such as larger buttons that can be pushed by a fist or bright colors to accommodate visual limitations.

Review the extent to which the facility adapts the physical environment to enable residents to maintain unassisted functioning. These adaptations include, but are not limited to:

- Furniture and adaptive equipment that enable residents to stand independently, transfer without assistance (e.g., arm supports, correct chair height and depth, firm support), maintain body symmetry, participate in resident-preferred activities, and promote mobility and independence for residents in going to the bathroom (e.g., grab bars, elevated toilet seats).
- Easily useable fixtures, drawer handles, faucets, etc.;
- Personal items kept within reach for independent use in the bathroom; and
- Bedroom furniture arranged to the residents’ preferences as much as possible.

Determine if staff use appropriate measures to facilitate communication with residents who have difficulty communicating. For example, do staff communicate at eye level, and do they remove a resident from noisy surroundings if that resident is having difficulty hearing what is said?

If the facility has outdoor smoking areas, how have they accommodated residents when the weather is inclement?

F247

(Rev. 48, Issued: 06-12-09, Effective: 06-12-09 Implementation: 06-12-09)
A resident has a right to—

§483.15(e)(2) - Receive notice before the resident’s room or roommate in the facility is changed.

Interpretive Guidelines §483.15(e)(2)
The facility should be sensitive to the trauma a move or change of roommate causes some residents, and should attempt to be as accommodating as possible. This includes learning the resident’s preferences and taking them into account when discussing changes of rooms or roommates and the timing of such changes. For a resident who is being moved at the facility’s request, a staff member should explain to the resident the reason for the move and support the resident by providing the opportunity to see the new location and meet the new roommate, and to ask questions about the move. For a resident who is receiving a new roommate, a staff member should give the resident as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility should support a resident whose roommate has passed away by providing a little time to adjust (a couple days if possible) before moving another person into the room, depending on the resident’s level of connection to the previous roommate. The facility should provide necessary social services for a resident who is grieving over the death of a roommate. If the survey team identifies potential compliance issues related to social services, refer to §483.15(g)(1), Social Services, Tag F250.

F248
(Rev, 70, Issued: 01-07-11, Effective: 10-01-10 Implementation: 10-01-10)

§483.15(f) Activities

§483.15(f)(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

INTENT: §483.15(f)(1) Activities
The intent of this requirement is that:

• The facility identifies each resident's interests and needs; and

• The facility involves the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well-being.

DEFINITIONS
Definitions are provided to clarify key terms used in this guidance.
• “Activities” refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence.

NOTE: ADL-related activities, such as manicures/pedicures, hair styling, and makeovers, may be considered part of the activities program.

• “One-to-One Programming” refers to programming provided to residents who will not, or cannot, effectively plan their own activity pursuits, or residents needing specialized or extended programs to enhance their overall daily routine and activity pursuit needs.

• “Person Appropriate” refers to the idea that each resident has a personal identity and history that involves more than just their medical illnesses or functional impairments. Activities should be relevant to the specific needs, interests, culture, background, etc. of the individual for whom they are developed.

• “Program of Activities” includes a combination of large and small group, one-to-one, and self-directed activities; and a system that supports the development, implementation, and evaluation of the activities provided to the residents in the facility.

OVERVIEW

In long term care, an ongoing program of activities refers to the provision of activities in accordance with and based upon an individual resident’s comprehensive assessment. The Institute of Medicine (IOM)’s 1986 report, “Improving the Quality of Care in Nursing Homes,” became the basis for the “Nursing Home Reform” part of OBRA ‘87 and the current OBRA long term care regulations. The IOM Report identified the need for residents in nursing homes to receive care and/or services to maximize their highest practicable quality of life. However, defining “quality of life” has been difficult, as it is subjective for each person. Thus, it is important for the facility to conduct an individualized assessment of each resident to provide additional opportunities to help enhance a resident’s self-esteem and dignity.

Research findings and the observations of positive resident outcomes confirm that activities are an integral component of residents’ lives. Residents have indicated that daily life and involvement should be meaningful. Activities are meaningful when they reflect a person’s interests and lifestyle, are enjoyable to the person, help the person to feel useful, and provide a sense of belonging.

Residents’ Views on Activities

Activities are relevant and valuable to residents’ quality of life. In a large-scale study commissioned by CMS, 160 residents in 40 nursing homes were interviewed about what quality of life meant to them. The study found that residents “overwhelmingly assigned priority to dignity, although they labeled this concern in many ways.” The researchers determined that the two main components of dignity, in the words of these residents, were “independence” and “positive self-image.” Residents listed, under the categories of independence and positive self-
image, the elements of “choice of activities” and “activities that amount to something,” such as those that produce or teach something; activities using skills from residents’ former work; religious activities; and activities that contribute to the nursing home.

The report stated that, “Residents not only discussed particular activities that gave them a sense of purpose but also indicated that a lack of appropriate activities contributes to having no sense of purpose.” “Residents rarely mentioned participating in activities as a way to just ‘keep busy’ or just to socialize. The relevance of the activities to the residents’ lives must be considered.”

According to the study, residents wanted a variety of activities, including those that are not childish, require thinking (such as word games), are gender-specific, produce something useful, relate to previous work of residents, allow for socializing with visitors and participating in community events, and are physically active. The study found that the above concepts were relevant to both interviewable and non-interviewable residents. Researchers observed that non-interviewable residents appeared “happier” and “less agitated” in homes with many planned activities for them.

Non-traditional Approaches to Activities

Surveyors need to be aware that some facilities may take a non-traditional approach to activities.

In neighborhoods/households, all staff may be trained as nurse aides and are responsible to provide activities, and activities may resemble those of a private home. Residents, staff, and families may interact in ways that reflect daily life, instead of in formal activities programs.

Residents may be more involved in the ongoing activities in their living area, such as care-planned approaches including chores, preparing foods, meeting with other residents to choose spontaneous activities, and leading an activity. It has been reported that, “some culture changed homes might not have a traditional activities calendar, and instead focus on community life to include activities. Instead of an “activities director,” some homes have a Community Life Coordinator, a Community Developer, or other title for the individual directing the activities program.

For more information on activities in homes changing to a resident-directed culture, the following websites are available as resources: www.pioneernetwork.net; www.culturechangenow.com; www.qualitypartnersri.org (click on nursing homes); and www.edenalt.com.

ASSESSMENT

The information gathered through the assessment process should be used to develop the activities component of the comprehensive care plan. The ongoing program of activities should match the skills, abilities, needs, and preferences of each resident with the demands of the activity and the characteristics of the physical, social and cultural environments.
In order to develop individualized care planning goals and approaches, the facility should obtain sufficient, detailed information (even if the Activities RAP is not triggered) to determine what activities the resident prefers and what adaptations, if any, are needed.6

NOTE: RAPs have been replaced by CAAs. The above reference to the use of the RAP is interchangeable with the use of the CAA.

The facility may use, but need not duplicate, information from other sources, such as the RAI, including the CAAs, assessments by other disciplines, observation, and resident and family interviews. Other sources of relevant information include the resident’s lifelong interests, spirituality, life roles, goals, strengths, needs and activity pursuit patterns and preferences.7 This assessment should be completed by or under the supervision of a qualified professional (see F249 for definition of qualified professional).

NOTE: Some residents may be independently capable of pursuing their own activities without intervention from the facility. This information should be noted in the assessment and identified in the plan of care.

CARE PLANNING

Care planning involves identification of the resident’s interests, preferences, and abilities; and any issues, concerns, problems, or needs affecting the resident’s involvement/engagement in activities.8 In addition to the activities component of the comprehensive care plan, information may also be found in a separate activity plan, on a CNA flow sheet, in a progress note, etc.

Activity goals related to the comprehensive care plan should be based on measurable objectives and focused on desired outcomes (e.g., engagement in an activity that matches the resident’s ability, maintaining attention to the activity for a specified period of time, expressing satisfaction with the activity verbally or non-verbally), not merely on attendance at a certain number of activities per week.

NOTE: For residents with no discernable response, service provision is still expected and may include one-to-one activities such as talking to the resident, reading to the resident about prior interests, or applying lotion while stroking the resident’s hands or feet. Activities can occur at any time, are not limited to formal activities being provided only by activities staff, and can include activities provided by other facility staff, volunteers, visitors, residents, and family members. All relevant departments should collaborate to develop and implement an individualized activities program for each resident. Some medications, such as diuretics, or conditions such as pain, incontinence, etc. may affect the resident’s participation in activities. Therefore, additional steps may be needed to facilitate the resident’s participation in activities, such as:

- If not contraindicated, timing the administration of medications, to the extent possible, to avoid interfering with the resident’s ability to participate or to remain at a scheduled activity; or
• If not contraindicated, modifying the administration time of pain medication to allow the medication to take effect prior to an activity the resident enjoys.

The care plan should also identify the discipline(s) that will carry out the approaches. For example:

• Notifying residents of preferred activities;

• Transporting residents who need assistance to and from activities (including indoor, outdoor, and outings);

• Providing needed functional assistance (such as toileting and eating assistance); and

• Providing needed supplies or adaptations, such as obtaining and returning audio books, setting up adaptive equipment, etc.

Concepts the facility should have considered in the development of the activities component of the resident’s comprehensive care plan include the following, as applicable to the resident:

• A continuation of life roles, consistent with resident preferences and functional capacity (e.g., to continue work or hobbies such as cooking, table setting, repairing small appliances);

• Encouraging and supporting the development of new interests, hobbies, and skills (e.g., training on using the Internet); and

• Connecting with the community, such as places of worship, veterans’ groups, volunteer groups, support groups, wellness groups, athletic or educational connections (via outings or invitations to outside groups to visit the facility).

The facility may need to consider accommodations in schedules, supplies and timing in order to optimize a resident’s ability to participate in an activity of choice. Examples of accommodations may include, but are not limited to:

• Altering a therapy or a bath/shower schedule to make it possible for a resident to attend a desired activity that occurs at the same time as the therapy session or bath;

• Assisting residents, as needed, to get to and participate in desired activities (e.g., dressing, toileting, transportation);

• Providing supplies (e.g., books/magazines, music, craft projects, cards, sorting materials) for activities, and assistance when needed, for residents’ use (e.g., during weekends, nights, holidays, evenings, or when the activities staff are unavailable); and

• Providing a late breakfast to allow a resident to continue a lifelong pattern of attending religious services before eating.
INTERVENTIONS

The concept of individualized intervention has evolved over the years. Many activity professionals have abandoned generic interventions such as “reality orientation” and large-group activities that include residents with different levels of strengths and needs. In their place, individualized interventions have been developed based upon the assessment of the resident’s history, preferences, strengths, and needs. These interventions have changed from the idea of “age-appropriate” activities to promoting “person-appropriate” activities. For example, one person may care for a doll or stroke a stuffed animal, another person may be inclined to reminisce about dolls or stuffed animals they once had, while someone else may enjoy petting a dog but will not be interested in inanimate objects. The surveyor observing these interventions should determine if the facility selected them in response to the resident’s history and preferences. Many activities can be adapted in various ways to accommodate the resident’s change in functioning due to physical or cognitive limitations.

Some Possible Adaptations that May be Made by the Facility 10, 11

When evaluating the provision of activities, it is important for the surveyor to identify whether the resident has conditions and/or issues for which staff should have provided adaptations.

Examples of adaptations for specific conditions include, but are not limited to the following:

- For the resident with visual impairments: higher levels of lighting without glare; magnifying glasses, light-filtering lenses, telescopic glasses; use of “clock method” to describe where items are located; description of sizes, shapes, colors; large print items including playing cards, newsprint, books; audio books;

- For the resident with hearing impairments: small group activities; placement of resident near speaker/activity leader; use of amplifiers or headphones; decreased background noise; written instructions; use of gestures or sign language to enhance verbal communication; adapted TV (closed captioning, magnified screen, earphones);

- For the resident who has physical limitations, the use of adaptive equipment, proper seating and positioning, placement of supplies and materials12 (based on clinical assessment and referral as appropriate) to enhance:
  - Visual interaction and to compensate for loss of visual field (hemianopsia);
  - Upper extremity function and range of motion (reach);
  - Hand dexterity (e.g., adapted size of items such as larger handles for cooking and woodworking equipment, built-up paintbrush handles, large needles for crocheting);
  - The ability to manipulate an item based upon the item’s weight, such as lighter weight for residents with muscle weakness13;
• For the resident who has the use of only one hand: holders for kitchen items, magazines/books, playing cards; items (e.g., art work, bingo card, nail file) taped to the table; c-clamp or suction vise to hold wood for sanding;

• For the resident with cognitive impairment: task segmentation and simplification; programs using retained long-term memory, rather than short-term memory; length of activities based on attention span; settings that recreate past experiences or increase/decrease stimulation; smaller groups without interruption; one-to-one activities;

**NOTE:** The length, duration, and content of specific one-to-one activities are determined by the specific needs of the individual resident, such as several short interventions (rather than a few longer activities) if someone has extremely low tolerance, or if there are behavioral issues. Examples of one-to-one activities may include any of the following:

- Sensory stimulation or cognitive therapy (e.g., touch/visual/auditory stimulation, reminiscence, or validation therapy) such as special stimulus rooms or equipment; alerting/upbeat music and using alerting aromas or providing fabrics or other materials of varying textures;

- Social engagement (e.g., directed conversation, initiating a resident to resident conversation, pleasure walk or coffee visit);

- Spiritual support, nurturing (e.g., daily devotion, Bible reading, or prayer with or for resident per religious requests/desires);

- Creative, task-oriented activities (e.g., music or pet activities/therapy, letter writing, word puzzles); or

- Support of self-directed activity (e.g., delivering of library books, craft material to rooms, setting up talking book service).

• For the resident with a language barrier: translation tools; translators; or publications and/or audio/video materials in the resident’s language;

• For residents who are terminally ill: life review; quality time with chosen relatives, friends, staff, and/or other residents; spiritual support; touch; massage; music; and/or reading to the resident;

**NOTE:** Some residents may prefer to spend their time alone and introspectively. Their refusal of activities does not necessarily constitute noncompliance.

• For the resident with pain: spiritual support, relaxation programs, music, massage, aromatherapy, pet therapy/pet visits, and/or touch;
• For the resident who prefers to stay in her/his own room or is unable to leave her/his room: in-room visits by staff/other residents/volunteers with similar interests/hobbies; touch and sensory activities such as massage or aromatherapy; access to art/craft materials, cards, games, reading materials; access to technology of interest (computer, DVD, hand held video games, preferred radio programs/stations, audio books); and/or visits from spiritual counselors; 14

• For the resident with varying sleep patterns, activities are available during awake time. Some facilities use a variety of options when activities staff are not available for a particular resident: nursing staff reads a newspaper with resident; dietary staff makes finger foods available; CNA works puzzle with the resident; maintenance staff take the resident on night rounds; and/or early morning delivery of coffee/juice to residents;

• For the resident who has recently moved-in: welcoming activities and/or orientation activities;

• For the short-stay resident: “a la carte activities” are available, such as books, magazines, cards, word puzzles, newspapers, CDs, movies, and handheld games; interesting/contemporary group activities are offered, such as dominoes, bridge, Pinochle, poker, video games, movies, and travelogues; and/or individual activities designed to match the goals of therapy, such as jigsaw puzzles to enhance fine motor skills;

• For the younger resident: individual and group music offerings that fit the resident’s taste and era; magazines, books and movies that fit the resident’s taste and era; computer and Internet access; and/or contemporary group activities, such as video games, and the opportunity to play musical instruments, card and board games, and sports; and

• For residents from diverse ethnic or cultural backgrounds: special events that include meals, decorations, celebrations, or music; visits from spiritual leaders and other individuals of the same ethnic background; printed materials (newspapers, magazines) about the resident’s culture; and/or opportunities for the resident and family to share information about their culture with other residents, families, and staff.

Activity Approaches for Residents with Behavioral Symptoms 15, 7

When the surveyor is evaluating the activities provided to a resident who has behavioral symptoms, they may observe that many behaviors take place at about the same time every day (e.g., before lunch or mid-afternoon). The facility may have identified a resident’s pattern of behavior symptoms and may offer activity interventions, whenever possible, prior to the behavior occurring. Once a behavior escalates, activities may be less effective or may even cause further stress to the resident (some behaviors may be appropriate reactions to feelings of discomfort, pain, or embarrassment, such as aggressive behaviors exhibited by some residents with dementia during bathing 16). Examples of activities-related interventions that a facility may provide to try to minimize distressed behavior may include, but are not limited to the following:

For the resident who is constantly walking:
• Providing a space and environmental cues that encourages physical exercise, decreases exit behavior and reduces extraneous stimulation (such as seating areas spaced along a walking path or garden; a setting in which the resident may manipulate objects; or a room with a calming atmosphere, for example, using music, light, and rocking chairs);

• Providing aroma(s)/aromatherapy that is/are pleasing and calming to the resident; and

• Validating the resident’s feelings and words; engaging the resident in conversation about who or what they are seeking; and using one-to-one activities, such as reading to the resident or looking at familiar pictures and photo albums.

For the resident who engages in name-calling, hitting, kicking, yelling, biting, sexual behavior, or compulsive behavior:

• Providing a calm, non-rushed environment, with structured, familiar activities such as folding, sorting, and matching; using one-to-one activities or small group activities that comfort the resident, such as their preferred music, walking quietly with the staff, a family member, or a friend; eating a favorite snack; looking at familiar pictures;

• Engaging in exercise and movement activities; and

• Exchanging self-stimulatory activity for a more socially-appropriate activity that uses the hands, if in a public space.

For the resident who disrupts group activities with behaviors such as talking loudly and being demanding, or the resident who has catastrophic reactions such as uncontrolled crying or anger, or the resident who is sensitive to too much stimulation:

• Offering activities in which the resident can succeed, that are broken into simple steps, that involve small groups or are one-to-one activities such as using the computer, that are short and repetitive, and that are stopped if the resident becomes overwhelmed (reducing excessive noise such as from the television);

• Involving in familiar occupation-related activities. (A resident, if they desire, can do paid or volunteer work and the type of work would be included in the resident’s plan of care, such as working outside the facility, sorting supplies, delivering resident mail, passing juice and snacks, refer to F169, Work);

• Involving in physical activities such as walking, exercise or dancing, games or projects requiring strategy, planning, and concentration, such as model building, and creative programs such as music, art, dance or physically resistive activities, such as kneading clay, hammering, scrubbing, sanding, using a punching bag, using stretch bands, or lifting weights; and

• Slow exercises (e.g., slow tapping, clapping or drumming); rocking or swinging motions (including a rocking chair).
For the resident who goes through others’ belongings:

• Using normalizing activities such as stacking canned food onto shelves, folding laundry; offering sorting activities (e.g., sorting socks, ties or buttons); involving in organizing tasks (e.g., putting activity supplies away); providing rummage areas in plain sight, such as a dresser; and

• Using non-entry cues, such as “Do not disturb” signs or removable sashes, at the doors of other residents’ rooms; providing locks to secure other resident’s belongings (if requested).

For the resident who has withdrawn from previous activity interests/customary routines and isolates self in room/bed most of the day:

• Providing activities just before or after meal time and where the meal is being served (out of the room);

• Providing in-room volunteer visits, music or videos of choice;

• Encouraging volunteer-type work that begins in the room and needs to be completed outside of the room, or a small group activity in the resident’s room, if the resident agrees; working on failure-free activities, such as simple structured crafts or other activity with a friend; having the resident assist another person;

• Inviting to special events with a trusted peer or family/friend;

• Engaging in activities that give the resident a sense of value (e.g., intergenerational activities that emphasize the resident's oral history knowledge);

• Inviting resident to participate on facility committees;

• Inviting the resident outdoors; and

• Involving in gross motor exercises (e.g., aerobics, light weight training) to increase energy and uplift mood.

For the resident who excessively seeks attention from staff and/or peers: Including in social programs, small group activities, service projects, with opportunities for leadership.

For the resident who lacks awareness of personal safety, such as putting foreign objects in her/his mouth or who is self-destructive and tries to harm self by cutting or hitting self, head banging, or causing other injuries to self:

• Observing closely during activities, taking precautions with materials (e.g., avoiding sharp objects and small items that can be put into the mouth);

• Involving in smaller groups or one-to-one activities that use the hands (e.g., folding towels, putting together PVC tubing);
• Focusing attention on activities that are emotionally soothing, such as listening to music or talking about personal strengths and skills, followed by participation in related activities; and

• Focusing attention on physical activities, such as exercise.

For the resident who has delusional and hallucinatory behavior that is stressful to her/him:

• Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities and physical activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident’s experience is real to her/him.

The outcome for the resident, the decrease or elimination of the behavior, either validates the activity intervention or suggests the need for a new approach.

ENDNOTES

INVESTIGATIVE PROTOCOL

ACTIVITIES

Objective
To determine if the facility has provided an ongoing program of activities designed to accommodate the individual resident’s interests and help enhance her/his physical, mental and psychosocial well-being, according to her/his comprehensive resident assessment.

Use
Use this procedure for each sampled resident to determine through interview, observation and record review whether the facility is in compliance with the regulation.

Procedures
Briefly review the comprehensive assessment and interdisciplinary care plan to guide observations to be made.

1. Observations
Observe during various shifts in order to determine if staff are consistently implementing those portions of the comprehensive plan of care related to activities. Determine if staff take into account the resident’s food preferences and restrictions for activities that involve food, and provide ADL assistance and adaptive equipment as needed during activities programs. For a resident with personal assistive devices such as glasses or hearing aides, determine if these devices are in place, glasses are clean, and assistive devices are functional.

For a resident whose care plan includes group activities, observe if staff inform the resident of the activities program schedule and provide timely transportation, if needed, for the resident to attend in-facility activities and help the resident access transportation to out-of-facility and community activities.

Determine whether the facility provides activities that are compatible with the resident’s known interests, needs, abilities and preferences. If the resident is in group activity programs, note if the resident is making attempts to leave, or is expressing displeasure with, or sleeping through, an activity program. If so, determine if staff attempted to identify the reason the resident is
attempting to leave, and if they addressed the resident’s needs. Determine whether the group activity has been adapted for the resident as needed and whether it is “person appropriate.”

**NOTE:** If you observe an activity that you believe would be age inappropriate for most residents, investigate further to determine the reason the resident and staff selected this activity. The National Alzheimer’s Association has changed from endorsing the idea of “age-appropriate” activities to promoting “person-appropriate” activities. In general, surveyors should not expect to see the facility providing dolls or stuffed animals for most residents, but some residents are attached to these items and should be able to continue having them available if they prefer.

Regarding group activities in common areas, determine if the activities are occurring in rooms that have sufficient space, light, ventilation, equipment and supplies. Sufficient space includes enough space for residents to participate in the activity and space for a resident to enter and leave the room without having to move several other residents. Determine if the room is sufficiently free of extraneous noise, such as environmental noises from mechanical equipment and staff interruptions.

For a resident who is involved in individual activities in her/his room, observe if staff have provided needed assistance, equipment and supplies. Observe if the room has sufficient light and space for the resident to complete the activity.

2. Interviews

**Resident/Representative Interview.** Interview the resident, family or resident representative as appropriate to identify their involvement in care plan development, defining the approaches and goals that reflect the resident’s preferences and choices. Determine:

- What assistance, if any, the facility should be providing to facilitate participation in activities of choice and whether or not the assistance is being provided;

- Whether the resident is participating in chosen activities on a regular basis, and if not, why not;

- Whether the resident is notified of activities opportunities and is offered transportation assistance as needed to the activity location within the facility or access to transportation, where available and feasible, to outside activities;

- Whether the facility tried, to the extent possible, to accommodate the resident’s choices regarding her/his schedule, so that service provision (for example, bathing and therapy services) does not routinely conflict with desired activities;

- Whether planned activity programs usually occur as scheduled (instead of being cancelled repeatedly); and

- Whether the resident desires activities that the facility does not provide.
If the resident has expressed any concerns, determine if the resident has discussed these with staff and, if so, what was the staff’s response.

**Activity Staff Interview**
Interview activities staff as necessary to determine:

- The resident’s program of activities and related goals;
- What assistance/adaptations they provide in group activities according to the resident’s care plan;
- How regularly the resident participates; if not participating, what is the reason(s);
- How they assure the resident is informed of, and transported to, group activities of choice;
- How special dietary needs and restrictions are handled during activities involving food;
- What assistance they provide if the resident participates in any individual (non-group) activities; and
- How they assure the resident has sufficient supplies, lighting, and space for individual activities.

**CNA Interview**
Interview CNAs as necessary to determine what assistance, if needed, the CNA provides to help the resident participate in desired group and individual activities, specifically:

- Their role in ensuring the resident is out of bed, dressed, and ready to participate in chosen group activities, and in providing transportation if needed;
- Their role in providing any needed ADL assistance to the resident while she/he is participating in group activities;
- Their role in helping the resident to participate in individual activities (if the resident’s plan includes these), for example, setup of equipment/supplies, positioning assistance, providing enough lighting and space; and
- How activities are provided for the resident at times when activities staff are not available to provide care planned activities.

**Social Services Staff Interview**
Interview the social services staff member as necessary to determine how they help facilitate resident participation in desired activities; specifically, how the social services staff member:
• Addresses the resident’s psychosocial needs that impact on the resident’s ability to participate in desired activities;

• Obtains equipment and/or supplies that the resident needs in order to participate in desired activities (for example, obtaining audio books, helping the resident replace inadequate glasses or a hearing aid); and

• Helps the resident access his/her funds in order to participate in desired activities that require money, such as attending concerts, plays, or restaurant dining events.

Nurse Interview
Interview a nurse who supervises CNAs who work with the resident to determine how nursing staff:

• Assist the resident in participating in activities of choice by:

  o Coordinating schedules for ADLs, medications, and therapies, to the extent possible, to maximize the resident’s ability to participate;

  o Making nursing staff available to assist with activities in and out of the facility;

• If the resident is refusing to participate in activities, how they try to identify and address the reasons; and

• Coordinate the resident’s activities participation when activities staff are not available to provide care planned activities.

3. Record Review

Assessment

Review the RAI, activity documentation/notes, social history, discharge information from a previous setting, and other interdisciplinary documentation that may contain information regarding the resident’s activity interests, preferences and needed adaptations.

Compare information obtained by observation of the resident and interviews with staff and the resident/responsible party (as possible), to the information in the resident’s record, to help determine if the assessment accurately and comprehensively reflects the resident’s status.

Determine whether staff have identified:

• Longstanding interests and customary routine, and how the resident’s current physical, mental, and psychosocial health status affects her/his choice of activities and her/his ability to participate;
Specific information about how the resident prefers to participate in activities of interest (for example, if music is an interest, what kinds of music; does the resident play an instrument; does the resident have access to music to which she/he likes to listen; and can the resident participate independently, such as inserting a CD into a player);

Any significant changes in activity patterns before or after admission;

The resident’s current needs for special adaptations in order to participate in desired activities (e.g., auditory enhancement or equipment to help compensate for physical difficulties such as use of only one hand);

The resident’s needs, if any, for time-limited participation, such as a short attention span or an illness that permits only limited time out of bed;

The resident’s desired daily routine and availability for activities; and

The resident’s choices for group, one-to-one, and self-directed activities.

Comprehensive Care Planning

Review the comprehensive care plan to determine if that portion of the plan related to activities is based upon the goals, interests, and preferences of the resident and reflects the comprehensive assessment. Determine if the resident’s care plan:

Includes participation of the resident (if able) or the resident’s representative;

Considers a continuation of life roles, consistent with resident preferences and functional capacity;

Encourages and supports the development of new interests, hobbies, and skills;

Identifies activities in the community, if appropriate;

Includes needed adaptations that address resident conditions and issues affecting activities participation; and

Identifies how the facility will provide activities to help the resident reach the goal(s) and who is responsible for implementation (e.g., activity staff, CNAs, dietary staff).

If care plan concerns are noted, interview staff responsible for care planning regarding the rationale for the current plan of care.

Care Plan Revision

Determine if the staff have evaluated the effectiveness of the care plan related to activities and made revisions, if necessary, based upon the following:
• Changes in the resident’s abilities, interests, or health;

• A determination that some aspects of the current care plan were unsuccessful (e.g., goals were not being met);

• The resident refuses, resists, or complains about some chosen activities;

• Changes in time of year have made some activities no longer possible (e.g., gardening outside in winter) and other activities have become available; and

• New activity offerings have been added to the facility’s available activity choices.

For the resident who refused some or all activities, determine if the facility worked with the resident (or representative, as appropriate) to identify and address underlying reasons and offer alternatives.

DETERMINATION OF COMPLIANCE (Task 6, Appendix P)

Synopsis of Regulation (F248)

This requirement stipulates that the facility’s program of activities should accommodate the interests and well-being of each resident. In order to fulfill this requirement, it is necessary for the facility to gain awareness of each resident’s activity preferences as well as any current limitations that require adaptation in order to accommodate these preferences.

Criteria for Compliance

The facility is in compliance with this requirement if they:

• Recognized and assessed for preferences, choices, specific conditions, causes and/or problems, needs and behaviors;

• Defined and implemented activities in accordance with resident needs and goals;

• Monitored and evaluated the resident’s response; and

• Revised the approaches as appropriate.

If not, cite at F248.

Noncompliance for Tag F248

After completing the Investigative Protocol, analyze the information gained in order to determine whether noncompliance with the regulation exists. Activities (F248) is an outcome-oriented requirement in that compliance is determined separately for each resident sampled. The survey
team’s review of the facility’s activities program is conducted through a review of the individualization of activities to meet each resident’s needs and preferences. For each sampled resident for whom activities participation was reviewed, the facility is in compliance if they have provided activities that are individualized to that resident’s needs and preferences, and they have provided necessary adaptations to facilitate the resident’s participation. Non compliance with F248 may look like, but is not limited to the following:

The facility does not have an activity program and does not offer any activities to the resident;

- A resident with special needs does not receive adaptations needed to participate in individualized activities;

- Planned activities were not conducted or designed to meet the resident’s care plan;

Potential Tags for Additional Investigation

During the investigation of the provision of care and services related to activities, the surveyor may have identified concerns with related outcome, process and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether noncompliance may be present. Some examples of requirements that should be considered include the following (not all inclusive):

- 42 CFR 483.10(e), F164, Privacy and Confidentiality
  - Determine if the facility has accommodated the resident’s need for privacy for visiting with family, friends, and others, as desired by the resident.

- 42 CFR 483.10(j)(1) and (2), F172, Access and Visitation Rights
  - Determine if the facility has accommodated the resident’s family and/or other visitors (as approved by the resident) to be present with the resident as much as desired, even round-the-clock.

- 42 CFR 483.15(b), F242, Self-Determination and Participation
  - Determine if the facility has provided the resident with choices about aspects of her/his life in the facility that are significant to the resident.

- 42 CFR 483.15(e)(1), F246, Accommodation of Needs
  - Determine if the facility has provided reasonable accommodation to the resident’s physical environment (room, bathroom, furniture, etc.) to accommodate the resident’s individual needs in relation to the pursuit of individual activities, if any.

- 42 CFR 483.15(f)(2), F249, Qualifications of the Activities Director
  - Determine if a qualified activities director is directing the activities program.
• 42 CFR 483.15(g)(1), F250, Social Services
  o Determine if the facility is providing medically-related social services related to assisting with obtaining supplies/equipment for individual activities (if any), and assisting in meeting the resident’s psychosocial needs related to activity choices.

• 43 CFR 483.20(b)(1), F272, Comprehensive Assessment
  o Determine if the facility assessed the resident’s activity needs, preferences, and interests specifically enough so that an individualized care plan could be developed.

• 43 CFR 483.20(k)(1), F279, Comprehensive Care Plan
  o Determine if the facility developed specific and individualized activities goals and approaches as part of the comprehensive care plan, unless the resident is independent in providing for her/his activities without facility intervention.

• 43 CFR 483.20(k)(2), F280, Care Plan Revision
  o Determine whether the facility revised the plan of care as needed with input of the resident (or representative, as appropriate).

• 43 CFR 483.30(a), F353, Sufficient Staff
  o Determine if the facility had qualified staff in sufficient numbers to assure the resident was provided activities based upon the comprehensive assessment and care plan.

• 43 CFR 483.70(g), F464, Dining and Activities Rooms
  o Determine if the facility has provided sufficient space to accommodate the activities and the needs of participating residents and that space is well lighted, ventilated, and adequately furnished.

• 43 CFR 483.75(g), F499, Staff Qualifications
  o Determine if the facility has employed sufficient qualified professional staff to assess residents and to develop and implement the activities approaches of their comprehensive care plans.

V. DEFICIENCY CATEGORIZATION (Part V, Appendix P)
Deficiencies at F248 are most likely to have psychosocial outcomes. The survey team should compare their findings to the various levels of severity on the Psychosocial Outcome Severity Guide at Appendix P, Part V.
§483.15(f)(2) The activities program must be directed by a qualified professional who--

(i) Is a qualified therapeutic recreation specialist or an activities professional who--

(A) Is licensed or registered, if applicable, by the State in which practicing; and

(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or

(iii) Is a qualified occupational therapist or occupational therapy assistant; or

(iv) Has completed a training course approved by the State.

INTENT: (F249) §483.15(f)(2) Activities Director

The intent of this regulation is to ensure that the activities program is directed by a qualified professional.

DEFINITIONS

“Recognized accrediting body” refers to those organizations that certify, register, or license therapeutic recreation specialists, activity professionals, or occupational therapists.

ACTIVITIES DIRECTOR RESPONSIBILITIES

An activity director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. This includes the completion and/or directing/delegating the completion of the activities component of the comprehensive assessment; and contributing to and/or directing/delegating the contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident.

Directing the activity program includes scheduling of activities, both individual and groups, implementing and/or delegating the implementation of the programs, monitoring the response and/or reviewing/evaluating the response to the programs to determine if the activities meet the assessed needs of the resident, and making revisions as necessary.

NOTE: Review the qualifications of the activities director if there are concerns with the facility’s compliance with the activities requirement at §483.15(f)(1), F248, or if there are concerns with the direction of the activity programs.
A person is a qualified professional under this regulatory tag if they meet any one of the qualifications listed under 483.15(f)(2).

**DETERMINATION OF COMPLIANCE (Task 6, Appendix P)**

**Synopsis of Regulation (F249)**

This requirement stipulates that the facility’s program of activities be directed by a qualified professional.

**Criteria for Compliance**

The facility is in compliance with this requirement if they:

- Have employed a qualified professional to provide direction in the development and implementation of activities in accordance with resident needs and goals, and the director:
  - Has completed or delegated the completion of the activities component of the comprehensive assessment;
  - Contributed or directed the contribution to the comprehensive care plan of activity goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident;
  - Has monitored and evaluated the resident’s response to activities and revised the approaches as appropriate; and
  - Has developed, implemented, supervised and evaluated the activities program.

If not, cite at F249.

**Noncompliance for F249**

Tag F249 is a tag that is absolute, which means the facility must have a qualified activities professional to direct the provision of activities to the residents. Thus, it is cited if the facility is non-compliant with the regulation, whether or not there have been any negative outcomes to residents.

Noncompliance for F249 may include (but is not limited to) one or more of the following, including:

- Lack of a qualified activity director; or
- Lack of providing direction for the provision of an activity program;
V. DEFICIENCY CATEGORIZATION (Part V, Appendix P)

Once the team has completed its investigation, reviewed the regulatory requirements, and determined that noncompliance exists, the team must determine the severity of each deficiency, based on the resultant effect or potential for harm to the resident. The key elements for severity determination for F249 are as follows:

1. Presence of harm/negative outcome(s) or potential for negative outcomes due to a lack of an activities director or failure of the director to oversee, implement and/or provide activities programming.
   - Lack of the activity director’s involvement in coordinating/directing activities; or
   - Lack of a qualified activity director.

2. Degree of harm (actual or potential) related to the noncompliance.

Identify how the facility practices caused, resulted in, allowed or contributed to the actual or potential for harm:
   - If harm has occurred, determine level of harm; and
   - If harm has not yet occurred, determine the potential for discomfort to occur to the resident.

3. The immediacy of correction required.

Determine whether the noncompliance requires immediate correction in order to prevent serious injury, harm, impairment, or death to one or more residents.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety

Immediate jeopardy is not likely to be issued as it is unlikely that noncompliance with F249 could place a resident or residents into a situation with potential to sustain serious harm, injury or death.

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy

Level 3 indicates noncompliance that results in actual harm, and may include, but is not limited to the resident’s inability to maintain and/or reach his/her highest practicable well-being. In order to cite actual harm at this tag, the surveyor must be able to identify a relationship between noncompliance cited at Tag F248 (Activities) and failure of the provision and/or direction of the activity program by the activity director. For Severity Level 3, both of the following must be present:

1. Findings of noncompliance at Severity Level 3 at Tag F248; and
2. There is no activity director; or the facility failed to assure the activity director was responsible for directing the activity program in the assessment, development, implementation and/or revision of an individualized activity program for an individual resident; and/or the activity director failed to assure that the facility’s activity program was implemented.

**NOTE:** If Severity Level 3 (actual harm that is not immediate jeopardy) has been ruled out based upon the evidence, then evaluate as to whether Level 2 (no actual harm with the potential for more than minimal harm) exists.

**Severity Level 2 Considerations: No Actual Harm with Potential for more than Minimal Harm that is not Immediate Jeopardy**

Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well being. The potential exists for greater harm to occur if interventions are not provided. In order to cite Level 2 at Tag F249, the surveyor must be able to identify a relationship between noncompliance cited at Level 2 at Tag F248 (Activities) and failure of the provision and/or direction of activity program by the activity director. For Severity Level 2 at Tag F249, both of the following must be present:

1. Findings of noncompliance at Severity Level 2 at Tag F248; and  
2. There is no activity director; or the facility failed to involve the activity director in the assessment, development, implementation and/or revision of an individualized activity program for an individual resident; and/or the activity director failed to assure that the facility’s activity program was implemented.

**Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm**

In order to cite Level 1, no actual harm with potential for minimal harm at this tag, the surveyor must be able to identify that:

There is no activity director and/or the activity director is not qualified, however:

- Tag F248 was not cited;
- The activity systems associated with the responsibilities of the activity director are in place;
- There has been a relatively short duration of time without an activity director; and
- The facility is actively seeking a qualified activity director.
§483.15(g) Social Services

§483.15(g)(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Intent §483.15(g)
To assure that sufficient and appropriate social service are provided to meet the resident’s needs.

Interpretive Guidelines §483.15(g)(1)
Regardless of size, all facilities are required to provide for the medically related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. It is not required that a qualified social worker necessarily provide all of these services. Rather, it is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate disciplines.

“Medically-related social services” means services provided by the facility’s staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example:

• Making arrangements for obtaining needed adaptive equipment, clothing, and personal items;

• Maintaining contact with facility (with resident’s permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;

• Assisting staff to inform residents and those they designate about the resident’s health status and health care choices and their ramifications;

• Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);

• Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);

• Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);

• Providing or arranging provision of needed counseling services;

• Through the assessment and care planning process, identifying and seeking ways to support residents’ individual needs;
• Promoting actions by staff that maintain or enhance each resident’s dignity in full recognition of each resident’s individuality;

• Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;

• Finding options that most meet the physical and emotional needs of each resident;

• Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet;

• Meeting the needs of residents who are grieving; and

• Finding options which most meet their physical and emotional needs

Factors with a potentially negative effect on physical, mental, and psychosocial well being include an unmet need for:

• Dental /denture care;

• Podiatric care;

• Eye Care;

• Hearing services

• Equipment for mobility or assistive eating devices; and

• Need for home-like environment, control, dignity, privacy

Where needed services are not covered by the Medicaid State plan, nursing facilities are still required to attempt to obtain these services. For example, if a resident requires transportation services that are not covered under a Medicaid state plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer assistance.

Types of conditions to which the facility should respond with social services by staff or referral include:

• Lack of an effective family/support system;

• Behavioral symptoms;

• If a resident with dementia strikes out at another resident, the facility should evaluate the resident’s behavior. For example, a resident may be re-enacting an activity he or she used to perform at the same time everyday. If that resident senses that another is in the way of his re-enactment, the resident may strike out at the resident impeding his or her progress. The facility is responsible for the safety of any potential resident victims while it assesses the circumstances of the residents behavior);
• Presence of a chronic disabling medical or psychological condition (e.g., multiple sclerosis, chronic obstructive pulmonary disease, Alzheimer’s disease, schizophrenia);

• Depression

• Chronic or acute pain;

• Difficulty with personal interaction and socialization skills;

• Presence of legal or financial problems

• Abuse of alcohol or other drugs;

• Inability to cope with loss of function;

• Need for emotional support;

• Changes in family relationships, living arrangements, and/or resident’s condition or functioning; and

• A physical or chemical restraint.

• For residents with or who develop mental disorders as defined by the “Diagnostic and Statistical Manual for Mental Disorders (DSM-IV),” see §483.45, F406.

Probes: §483.15(g)(1)

For residents selected for a comprehensive or focused review as appropriate:

• How do facility staff implement social services interventions to assist the resident in meeting treatment goals?

• How do staff responsible for social work monitor the resident’s progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly?

• How does the care plan link goals to psychosocial functioning/well-being?

• Have the staff responsible for social work established and maintained relationships with the resident’s family or legal representative?

• [NFs] What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan?

Look for evidence that social services interventions successfully address residents’ needs and link social supports, physical care, and physical environment with residents’ needs and individuality.

For sampled residents, review the appropriate sections of the current MDS.
§483.15(g)(2) and (3)

(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

(3) Qualifications of a social worker. A qualified social worker is an individual with-

(i) A bachelor’s degree in social work or a bachelor’s degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

(ii) One year of supervised social work experience in a health care setting working directly with individuals

Procedures §483.15(g)(2) and (3)
If there are problems with the provision of social services in a facility with over 120 beds, determine if a qualified social worker is employed on a full time basis. See also F250.

§483.15(h) - Environment
The facility must provide--

§483.15(h)(1) - A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

Interpretive Guidelines: §483.15(h)(1)

For purposes of this requirement, “environment” refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents’ rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A determination of “homelike” should include the resident’s opinion of the living environment.

A “homelike environment” is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The intent of the word “homelike” in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. This concept of creating a home setting includes the elimination of institutional odors, and practices to the extent possible. Some good practices that serve to decrease the institutional character of the environment include the elimination of:
• Overhead paging and piped-in music throughout the building;

• Meal service in the dining room using trays (some residents may wish to eat certain meals in their rooms on trays);

• Institutional signage labeling work rooms/closets in areas visible to residents and the public;

• Medication carts (some innovative facilities store medications in locked areas in resident rooms);

• The widespread and long-term use of audible (to the resident) chair and bed alarms, instead of their limited use for selected residents for diagnostic purposes or according to their care planned needs. These devices can startle the resident and constrain the resident from normal repositioning movements, which can be problematic. For more information about the detriments of alarms in terms of their effects on residents and alternatives to the widespread use of alarms, see the 2007 CMS satellite broadcast training, “From Institutionalized to Individualized Care,” Part 1, available through the National Technical Information Service and other sources such as the Pioneer Network;

• Mass purchased furniture, drapes and bedspreads that all look alike throughout the building (some innovators invite the placement of some residents’ furniture in common areas); and

• Large, centrally located nursing/care team stations.

Many facilities cannot immediately make these types of changes, but it should be a goal for all facilities that have not yet made these types of changes to work toward them. A nursing facility is not considered non-compliant if it still has some of these institutional features, but the facility is expected to do all it can within fiscal constraints to provide an environment that enhances quality of life for residents, in accordance with resident preferences.

A “homelike” or homey environment is not achieved simply through enhancements to the physical environment. It concerns striving for person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each resident and makes her/him comfortable.

In a facility in which most residents come for a short-term stay, the "good practices" listed in this section are just as important as in a facility with a majority of long term care residents. A resident in the facility for a short-term stay would not typically move her/his bedroom furniture into the room, but may desire to bring a television, chair or other personal belongings to have while staying in the facility.

Although the regulatory language at this tag refers to “safe,” “clean,” “comfortable,” and “homelike,” for consistency, the following specific F-tags should be used for certain issues of safety and cleanliness:

• For issues of safety of the environment, presence of hazards and hazardous practices, use §483.25(h), Accidents, Tag F323;
For issues of fire danger, use §483.70(a) Life Safety from Fire, Tag F454;

For issues of cleanliness and maintenance of common living areas frequented by residents, use §483.15(h)(2), Housekeeping and Maintenance, Tag F254;

For issues of cleanliness of areas of the facility used by staff only (e.g., break room, medication room, laundry, kitchen, etc.) or the public only (e.g., parking lot), use §483.70(h), Tag F465 Other Environmental Conditions; and

Although this Tag can be used for issues of general comfortableness of the environment such as furniture, there are more specific Tags to use for the following issues:

- For issues of uncomfortable lighting, use §483.15(h)(5), Tag F256 Adequate and Comfortable Lighting;
- For issues of uncomfortable temperature, use §483.15(h)(6), Tag F257 Comfortable and Safe Temperature Levels; and
- For issues of uncomfortable noise levels, use §483.15(h)(7), Tag F258 Comfortable Sound Levels.

Procedures: §483.15(h)(1)
During interviews, ask residents and families whether they think the facility is striving to be as homelike as possible, and whether they have been invited to bring in desired personal property items (within space constraints). Observe bedrooms of sampled residents for personalization. By observing the residents’ surroundings, what can the survey team learn about their everyday life and interests? Their life prior to residing in the facility? Observe for family photographs, books and magazines, bedspreads, knickknacks, mementos, and furniture that belong to the residents. For residents who have no relatives or friends, and have few assets, determine the extent to which the facility has assisted these residents to make their rooms homelike, if they so desire. If potential issues are discovered, ask responsible staff about their efforts to provide a homelike environment and to invite residents to bring in personal belongings.

NOTE: Many residents who are residing in the facility for a short-term stay may not wish to personalize their rooms nor bring in many belongings. If they express no issues regarding homelike environment or personal property during interviews, there is no need to conduct further investigations for those residents.

§483.15(h)(2)

§483.15(h)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
Intent §483.15(h)(2)
The intent of this requirement is to focus on the facility’s responsibility to provide effective housekeeping and maintenance services.

Interpretive Guidelines §483.15(h)(2)
“Sanitary” includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes toothbrushes, dentures, denture cups, glasses and water pitchers, emesis basins, hair brushes and combs, bed pans, urinals, feeding tubes, leg bags and catheter bags, pads and positioning devices.

For kitchen sanitation, see §483.70(h), Other Environmental Conditions.

For facility-wide sanitary practices affecting the quality of care, see §483.65, Infection Control.

“Orderly” is defined as an uncluttered physical environment that is neat and well-kept.

Procedures §483.15(h)(2)
Balance the resident’s need for a homelike environment and the requirements of having a “sanitary” environment in a congregate living situation. For example, a resident may prefer a cluttered room, but does this clutter result in unsanitary or unsafe conditions?

Probes: §483.15(h)(2)
Is resident care equipment sanitary?
Is the area orderly?
Is the area uncluttered and in good repair?
Can residents and staff function unimpeded?

F254

§483.15(h)(3)
§483.15(h)(3) Clean bed and bath linens that are in good condition;

Probes: §483.15(h)(3)
Are bed linens clean and in good condition? Are there clean towels and wash cloths in good condition available for the resident?

F256
(Rev. 48, Issued: 06-12-09, Effective: 06-12-09 Implementation: 06-12-09)

§483.15(h)(5) - Environment
The facility must provide –
§483.15(h)(5) Adequate and comfortable lighting levels in all areas;

Interpretive Guidelines §483.15(h)(5)

“Adequate lighting” means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform.

“Comfortable lighting” means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of illumination so that visually impaired residents can maintain or enhance independent functioning.

As a person ages, their eyes usually change so that they require more light to see what they are doing and where they are going. An adequate lighting design has these features:

• Sufficient lighting with minimum glare in areas frequented by residents;

• Even light levels in common areas and hallways, avoiding patches of low light caused by too much space between light fixtures, within limits of building design constraints;

• Use of daylight as much as possible;

• Elimination of high levels of glare produced by shiny flooring and from unshielded window openings (no-shine floor waxes and light filtering curtains help to alleviate these sources of glare);

• Extra lighting, such as table and floor lamps to provide sufficient light to assist residents with tasks such as reading;

• Lighting for residents who need to find their way from bed to bathroom at night (e.g., red colored night lights preserve night vision); and

• Dimming switches in resident rooms (where possible and when desired by the resident) so that staff can tend to a resident at night with limited disturbances to them or a roommate. If dimming is not feasible, another option may be for staff to use flashlights/pen lights when they provide night care.

Some facilities may not be able to make some of these changes due to voltage or wiring issues.

For more information about adequate lighting design for long term care facilities, a facility may consult the lighting guidance available from the Illuminating Engineering Society of North America, which provides authoritative minimum lighting guidance.

The following are additional visual enhancements a facility should consider making as fiscal constraints permit in order to make it easier for residents with impaired vision to see and use their environment:
• Use of contrasting color between flooring and baseboard to enable residents with impaired vision to determine the horizontal plane of the floor;

• Use of contrast painting of bathroom walls and/or contrasting colored toilet seats so that residents with impaired vision can distinguish the toilet fixture from the wall; and

• Use of dishware that contrasts with the table or tablecloth color to aid residents with impaired vision to see their food.

**Procedures: §483.15(h)(5)**

Ask residents who receive resident interviews if they have sufficient lighting in all the areas they frequent in the facility that meets their needs, including (but not limited to):

• Available task lighting if this is desired;

• Elimination of excessive glare from windows and flooring;

• Wayfinding nighttime lighting for those residents who need it to find the bathroom); and

• Lights that can be dimmed, if desired, to eliminate being awakened by staff who are tending to their roommate.

Observe sampled residents throughout the survey and note if they are having difficulty reading or doing tasks due to insufficient lighting, or if they are wearing sunglasses or visors indoors due to glare, if they have difficulty seeing food on their plate, experiencing squinting or shading their eyes from glare or other signs that lighting does not meet their needs.

If these are observed, question the resident (if they are able to converse) as to how the lighting situation assists or hinders their pursuit of activities and independence. Discuss with staff these issues, their efforts to alleviate the problems, and any electrical issues in the building’s design that prevent making some of these changes.

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**F257**

§483.15(h)(6)

§483.15(h)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F; and

**Procedures §483.15(h)(6)**

“Comfortable and safe temperature levels” means that the ambient temperature should be in a relatively narrow range that minimizes residents’ susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory ailments and colds. Although there are no explicit temperatures standards for facilities certified on or before October 1, 1990, these facilities still must maintain safe and comfortable temperature levels.
For facilities certified after October 1, 1990, temperatures may exceed the upper range of 81° F for facilities in geographic areas of the country (primarily at the northernmost latitudes) where that temperature is exceeded only during rare, brief unseasonably hot weather. This interpretation would apply in cases where it does not adversely affect resident health and safety, and would enable facilities in areas of the country with relatively cold climates to avoid the expense of installing air conditioning equipment that would only be needed infrequently. Conversely, the temperatures may fall below 71° F for facilities in areas of the country where that temperature is exceeded only during brief episodes of unseasonably cold weather (minimum temperature must still be maintained at a sufficient level to minimize risk of hypothermia and susceptibility to loss of body heat, respiratory ailments and colds.)

Measure the air temperature above floor level in resident rooms, dining areas, and common areas. If the temperature is out of the 71-81 degree range, then ask staff what actions they take when residents complain of heat or cold, e.g., provide extra fluids during heat waves and extra blankets and sweaters in cold.

F258
§483.15(h)(7)

§483.15(h)(7) For the maintenance of comfortable sound levels.

Interpretive Guidelines §483.15(h)(7)
“Comfortable” sound levels do not interfere with resident’s hearing and enhance privacy when privacy is desired, and encourage interaction when social participation is desired. Of particular concern to comfortable sound levels is the resident’s control over unwanted noise.

Procedures §483.15(h)(7)

Determine if the sound levels are comfortable to residents. Do residents and staff have to raise their voices to communicate over background sounds? Are sound levels suitable for the activities occurring in that space during observation?

Consider whether residents have difficulty hearing or making themselves heard because of background sounds (e.g., overuse or excessive volume of intercom, shouting, loud TV, cleaning equipment). Consider if it is difficult for residents to concentrate because of distractions or background noises such as traffic, music, equipment, or staff behavior. Consider the comfort of sound levels based on the needs of the residents participating in a particular activity, e.g., the sound levels may have to be turned up for hard of hearing individuals watching TV or listening to the radio. Consider the effect of noise on the comfort of residents with dementia.

During resident reviews, ask residents if during evenings and at nighttime, sounds are at comfortable levels? (If yes) Have you told staff about it and how have they responded?