CMS Manual System

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Department of Health & Human Services (DHHS)
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Transmittal **Date:**

SUBJECT: Guidance to Surveyors of Long Term Care Facilities

I. SUMMARY OF CHANGES: State Operations Manual, Appendix PP, F248, Activities and F249, Activity Director – Guidance to Surveyors is entirely replaced with new Guidance, attached. (Regulation language is unchanged.)

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix PP/F248, Activities and F249, Activity Director

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

F248

(Rev.)

§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.[1]

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.[2]

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.[3] 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.[4]

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.[5]

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] The facility may use, but need not duplicate, information from other sources, such as the RAI, including the RAPs, 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)[9];

- 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 materials[12] (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 weakness[13];

- 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; [8]

  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

[1] Miller, M. E., Peckham, C. W., & Peckham, A. B. (1998). Activities keep me going and going (pp. 217-224). Lebanon, OH: Otterbein Homes.

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[4] Bowman, C. S. (2005). Living Life to the Fullest: A match made in OBRA '87. Milwaukee, WI: Action Pact, Inc.

[5] Glantz, C. G., & Richman, N. (2001). Leisure activities. In Occupational therapy: Practice skills for physical dysfunction. St Louis: Mosby.

[6] Glantz, C. G., & Richman, N. (1996). Evaluation and intervention for leisure activities, ROTE: Role of Occupational Therapy for the Elderly (2nd ed., p. 728). Bethesda, MD.: American Occupational Therapy Association.

[7] Glantz, C.G., & Richman, N. (1998). Creative methods, materials and models for training trainers in alzheimer's education (pp. 156-159). Riverwoods, IL: Glantz/Richman Rehabilitation Associates.

[8] Hellen, C. (1992). Alzheimer's disease: Activity-focused care (pp. 128-130). Boston, MA: Andover.

[9] American Occupational Therapy Association. (2002). Occupational therapy practice framework: domain & process. American Journal of Occupational Therapy, 56(6), 616-617. Bethesda, MD: American Occupational Therapy Association.

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[11] Pedretti, L. W. (1996). Occupational performance: A model for practice in physical dysfunction. In L.W. Pedretti (Ed.), Occupational therapy: Practice skills for physical dysfunction (4th ed., pp. 3-11). St. Louis: Mosby-Year Book

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[14] Glantz, C. G., & Richman, N. (1992). Activity programming for the resident with mental illness (pp. 53-76). Riverwoods, IL: Glantz/Richman Rehabilitation Associates.

[15] Day, K., & Calkins, M. P. (2002). Design and dementia. In R. B. Bechtel & A. Churchman (Eds.), Handbook of environmental psychology (pp. 374-393). New York: Wiley.

[16] Barrick, A. L., Rader, J., Hoeffer, B., & Sloane, P. (2002). Bathing without a battle: Personal care of individuals with dementia (p. 4). New York: Springer.

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.

<u>Activity Staff Interview</u>

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:

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

    - 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

    - 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

    - 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

    - 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

    - 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

    - 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

    - 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

    - 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.

F249

(Rev.)

§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.