Check List for Survey

* Activities Calendars from the last 3 month
* Resident Council Minutes from the last year
* Attendance Logs from the last 3 month

Check List of Activities Documentation

* MDS3.0 Section F completed within 14 days of Admission
* Activities Initial Assessment completed within 14 days of Admission
* Progress Notes done quarterly
* Consistent with residents needs and interests
* Attendance Logs
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check List for Resident Involvement

* 1-1 Documentation for Resident’s requiring 1-1 Activities
* Activities that meet the needs and interests of your residents

Regulations for Activities in Skilled Nursing (Federal)

**Effective November 28, 2017**

**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf**

***§483.24(c)* Activities. *§483.24(c)*(1) The facility must provide, *based on the comprehensive assessment and care plan and the preferences of each resident,* an ongoing program *to support residents in their choice* of activities, *both facility-sponsored group and individual activities and independent activities,* designed to meet the interests *of* and *support* the physical, mental, and psychosocial well-being of each resident, *encouraging both independence and interaction in the community.***

**INTENT *§483.24(c)***

To ensure that facilities implement an *ongoing resident centered* activities program that incorporates *the resident’s* interests, hobbies *and cultural* preferences which is integral to maintaining and/or improving a resident’s physical, mental, and psychosocial well-being *and independence. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).*

**DEFINITIONS *§483.24(c)* “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.

***GUIDANCE §483.24(c)***

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. *Maintaining contact and interaction with the community is an important aspect of a person’s well-being and facilitates feelings of connectedness and self-esteem. Involvement in community includes interactions such as assisting the resident to maintain his/her ability to independently shop, attend the community theater, local concerts, library, and participate in community groups.*

Activity Approaches for Residents with *Dementia All residents have a need for engagement in meaningful activities. For residents with dementia, the lack of engaging activities can cause boredom, loneliness and frustration, resulting in distress and agitation. Activities must be individualized and customized based on the resident’s previous lifestyle (occupation, family, hobbies), preferences and comforts. https://www.caringkindnyc.org/\_pdf/CaringKind-PalliativeCareGuidelines.pdf*

***NOTE****: References to non-CMS/HHS sources or sites on the Internet included above or later in this document are provided as a services and do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services. CMS is not responsible for the content of pages found at these sites. URL addresses were current at the date of this publication.*

The facility may have identified a resident’s pattern of behavioral 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 bathing16).

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 *exhibits unusual amounts of energy or* walking *without purpose*:

* Providing a space and environmental cues that encourages physical exercise, decreases exit-*seeking* 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 behaviors not conducive with a therapeutic home like environment:

* 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 exhibits behavior that require a less stimulating environment to discontinue behaviors not welcomed by others sharing their social space:

* 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 §*483.10(e)(8) Resident Right to 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 life 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. The facility may use, but need not duplicate, information from other sources, such as the RAI/*MDS* assessment, 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. This assessment should be completed by or under the supervision of a 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.

Surveyors need to be aware that some facilities may take a non-traditional approach to activities. In *nursing homes where culture change philosophy has been adopted,* all staff may be trained as nurse aides *or* “*universal workers,”* (workers with primary role but multiple duties outside of primary role)and *may be* responsible to provide activities, *which* may resemble those of a private home. *The provision of activities should not be confined to a department, but rather may involve all staff interacting with residents.*

Residents, staff, and families should 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.qualitypartnersri.org; and www.edenalt.org.

**INVESTIGATIVE SUMMARY**

Use the Activities Critical Element pathway and the guidance above to investigate concerns related to activities which are based on the resident’s comprehensive assessment and care plan, and meet the resident’s interests and preferences, and support his or her physical, mental, and psychosocial well-being.

***KEY ELEMENTS OF NONCOMPLIANCE* §483.*2*4(*c*)(*2*)**

*To cite deficient practice at F680, the surveyor's investigation will generally show that the facility failed to ensure the activities program is directed by a qualified professional, who:*

• *Is licensed or registered, (if applicable); and*

1. o *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*
2. o *Has 2 years of experience in a social or recreational program with the last 5 years, one of which was full-time in a therapeutic activities program; or*
3. o *Is a qualified occupational therapist or occupational therapy assistant; or*
4. o *Has completed a training course approved by the state.*

***NOTE****: F680* 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. *In determining the Scope and Severity, surveyors must consider the extent to which non-compliance at F679 is attributed to the lack of an activity director or the lack of qualifications of the activity director.*

**F565 *§483.10(f)(5)* The resident has a right to organize and participate in resident groups in the facility.**

***(i)* The facility must provide a resident or family group, if one exists, with private space; *and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.***

***(ii)* Staff, visitors, *or other guests* may attend *resident group or family group* meetings *only* at the *respective* group's invitation.**

***(iii)* The facility must provide a designated staff person *who is approved by the resident or family group and the facility and who is* responsible for providing assistance and responding to written requests that result from group meetings.**

***(iv) The facility* must *consider* the views *of a resident or family group* and act *promptly* upon the grievances and recommendations *of such groups* concerning *issues of* resident care and life in the facility.**

***(A) The facility must be able to demonstrate their response and rationale for such response.***

***(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.***

***§483.10(f)(6) The resident has a right to participate in family groups.***

***§483.10(f)(7) The resident has a right to have* family *member(s) or other resident representative(s)* meet in the facility with the families *or resident representative(s)* of other residents in the facility.**

**DEFINITIONS *§483.10(f)(5)-(7)* “A resident or family group”** is defined as a group of residents or residents’ family members that meets regularly to:

* Discuss and offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life;
* Support each other;
* Plan resident and family activities;
* Participate in educational activities; or
* For any other purpose.

***GUIDANCE §483.10(f)(5)-(7)***

This requirement does not require that residents organize a resident or family group. However, whenever residents or their families wish to organize, *they* must *be able* to do so without interference. *Additionally, they* must *be* provide*d* space, privacy for meetings, and staff support. *T*he designated staff person responsible for assistance and liaison between the group and the facility’s administration and any other staff members *may* attend the meeting only if *invited by the resident or family group. The resident or family group may meet without staff present*. *The groups should determine how frequently they meet.*

*F*acility *staff are* required to *consider* resident and family group *views* and *act upon* grievances and recommendations. *F*acility *staff* must consider *these* recommendations and attempt to accommodate *them*, to the extent practicable. *This may include* developing *or* changing policies affecting resident care and life. *F*acility *staff should discuss* its decisions *with* the resident and/or family group *and document in writing its response and rationale as required under 42 CFR §483.10(j), F585, Grievances.*

***PROCEDURES §483.10(f)(5)-(7)***

*During the entrance interview, determine:*

* *If there is a resident or family group;*
* *Who the resident or family representative is for each of these groups; and,*
* *Who the designated staff person is for assisting and working with each of these groups.*

*If residents or their families attempted to organize a group and were unsuccessful, why?*

*Through interviews with the representatives for the resident and family groups and staff designated for assisting and working with these groups, determine:*

* *Are groups able to meet without staff present unless desired?*
* *If a resident wants a family member present during a resident group meeting, how is this handled? Facility staff should not require said family member to leave the group meeting, without the permission of the group.*
* *How views, grievances or recommendations from these groups are considered, addressed and acted upon; and,*
* *How facility staff provide responses, actions, and rationale to the groups.*

*Examples of noncompliance may include, but are not limited to:*

* *Facility staff impede or prevent residents or family members ability to meet or organize a resident or family group;*
* *Resident and/or families were not always informed in advance of upcoming meetings.*
* *Facility staff impede with meetings and/or operations of family or resident council by mandating that they have a staff person in the room during meetings or assigning a staff person to liaise with the council that is not agreeable to the council;*
* *Private meeting space for these groups is not provided;*
* *The views, grievances or recommendations from these groups have not been considered or acted upon by facility staff;*
* *Facility staff does not provide these groups with responses, actions, and rationale taken regarding their concerns;*

**F675 § 483.*24* Quality of life *Quality of life is a fundamental principle that applies to all care and services provided to facility residents.* Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, *consistent with the resident’s* comprehensive assessment and plan of care.**

***INTENT***

*The intent of this requirement is to specify the facility’s responsibility to create and sustain an environment that humanizes and individualizes each resident’s quality of life by:*

* *Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and*
* *Ensuring that the care and services provided are person-centered, and honor and support each resident’s preferences, choices, values and beliefs.*

***DEFINITIONS §483.24 “Person Centered Care”*** *– For the purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. (Definitions -§483.5)*

***“Pervasive”*** *For the purposes of this guidance, pervasive means spread through or embedded within every part of something.*

***“Quality of Life”*** *An individual’s “sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem. For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one’s life.”*

***GUIDANCE §*483.*24***

*Noncompliance at F675 identifies outcomes which rise to the level of immediate jeopardy and reflect an environment of pervasive disregard for the quality of life of the facility’s residents. This can include the cumulative effect of noncompliance at other regulatory tags on one or more residents. To cite noncompliance at F675, the survey team must have evidence that outcomes at other regulatory tags demonstrate a pervasive disregard for the principles of quality of life.*

***Principles of Quality of Life***

*According to the 1986 Institute of Medicine (IOM) published report “Improving the Quality of Care in Nursing Homes,” principles of Quality of Life included:*

* *A sense of well-being, satisfaction with life, and feeling of self-worth and self-esteem; and*
* *A sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one’s life.*

*The report also identified that a sense of well-being, self-esteem, and self-worth was enhanced by personal control over choices, such as mealtimes, activities, clothing, and bedtime; privacy during visits, and treatments; and “opportunities to engage in religious, political, civic, recreational or other social activities. Based upon the regulatory requirement stating that quality of life is an overarching principle that applies to all care and services, the principles as identified in the IOM report above, will be used for determining whether a resident’s quality of life is being supported and or enhanced. Refer to this link for the entire IOM report: https://www.ncbi.nlm.nih.gov/books/NBK217548/#ddd00037*

*Facilities must create and sustain an environment that humanizes and promotes each resident’s well-being, and feeling of self-worth and self-esteem. This requires nursing home leadership to establish a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices, such as mealtimes, activities, clothing, and bedtime; privacy during visits, and treatments; and opportunities to engage in religious, political, civic, recreational or other social activities.*

**F680 *§483.24(c)*(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—**

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

***(ii)* Is:**

***(A) E*ligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or**

***(B)* Has 2 years of experience in a social or recreational program within the last 5 years, *one* of which was full-time in a *therapeutic* activities program; or**

***(C)* Is a qualified occupational therapist or occupational therapy assistant; or**

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

**INTENT §483.*2*4(*c*)(*2*)**

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

**DEFINITIONS §483.*2*4(*c*)(*2*) “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.*24*(*c*)(1), F*679*, 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 the qualifications (if applicable) of §483.*2*4(*c*)(*2*)(i), and one (or more) of the qualifications of §483.*2*4(*c*)(*2*)(ii).

**F550 *§483.10*(a) Resident Rights.**

**The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, *including those specified in this section.***

***§483.10(a)(1)* A facility must *treat each resident with respect and dignity and care for each resident* in a manner and in an environment that promotes maintenance or enhancement *of his or her* quality of life, *recognizing each resident’s individuality. The facility must protect and promote the rights of the resident.***

***§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.***

***§483.10(b)* Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.**

***§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.***

***§483.10(b)*(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights *and to be supported by the facility in the exercise of his or her rights as required under this subpart.***

**INTENT *§§483.10(a)-(b)(1)&(2)***

*All residents have rights guaranteed to them under Federal and State laws and regulations. This regulation is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on* assis*ting* the resident *in* maintain*ing* and enhanc*ing* his or her self-esteem and self-worth *and incorporating the resident’s, goals, preferences, and choices.* When providing care and services, *staff must respect each resident’s individuality, as well as honor and value their input.*

**GUIDANCE *§§483.10(a)-(b)(1)&(2)***

Examples *of treating residents with dignity and respect include, but are not limited to:*

* Encouraging and assisting residents to dress in their own clothes*, rather than hospital-type gowns, and appropriate footwear for* the time of day and individual preferences;
* *Placing labels on* each resident’s clothing in a way that *is inconspicuous and* respects his or her dignity (*for example,* placing labeling on the inside of shoes and clothing *or using a color coding system*);
* Promoting resident independence and dignity *while* dining, such as avoid*ing*:

1. o *Daily* use of *disposable* cutlery and dishware;
2. o Bibs *or* clothing protectors instead of napkins (except by resident choice);
3. o *Staff s*tanding over residents while assisting them to eat;
4. o *Staff i*nteracting/conversing only with each other rather than with residents while assisting *with meals;*

* *Protecting and valuing residents’* private space (*for example,* knocking on doors and requesting permission *before entering*, closing doors as requested by the resident);
* *Staff should* address residents with *the* name *or pronoun* of the resident’s choice, avoid*ing the* use of labels for residents such as “feeders” *or “walkers.*” *Residents should* not *be* exclud*ed* from conversations *during activities or when care is being provided, nor should staff* discuss residents *in settings where* others can overhear private or protected information *or document in charts/electronic health records where others can see a resident’s information*;
* Refraining from practices demeaning to residents such as *leaving* urinary catheter bags uncovered, refusing to comply with a resident’s request for *bathroom* 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.

*C*onsider the resident’s life style and personal choices *identified through their assessment processes* to obtain a picture of *his or her* individual needs and preferences.

*Staff and volunteers must interact with residents* in a *manner* that takes into account the physical limitations of the resident, assures communication, and maintains respect. *F*or example, getting down to eye level with a resident who is sitting, *maintaining eye contact when speaking with* a resident with limited hearing*, or* utilizing a hearing amplification device *when needed by a resident*.

*Pay close attention to resident or staff interactions that may represent deliberate actions to limit a resident’s autonomy or choice. These actions may indicate abuse. See F600, Free from Abuse, for guidance.*

The facility must not *establish policies or practices that* hamper, compel, treat differently, or retaliate against a resident for exercising his or her rights.

***Justice Involved Residents “Justice involved residents”*** *includes the following three categories:*

1. ***Residents under the care of law enforcement:*** *Residents who have been taken into custody by law enforcement. Law enforcement includes local and state police, sheriffs, federal law enforcement agents, and other deputies charged with enforcing the law.*
2. ***Residents under community supervision:*** *Residents who are on parole, on probation, or required to conditions of ongoing supervision and treatment as an alternative to criminal prosecution by a court of law.*
3. ***Inmates of a public institution:*** *Residents currently in custody and held involuntarily through operation of law enforcement authorities in an institution, which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, such as state or federal prisons, local jails, detention facilities, or other penal settings (such as boot camps, wilderness camps).*

*Justice involved individuals are entitled to the same rights described in 42 CFR Part 483, Subpart B as all other residents residing in the facility. The facility shall not establish policies or impose conditions on the justice involved resident that result in restrictions which violate the resident’s rights. Some Department of Corrections or law enforcement terms of release or placement may conflict with CMS requirements. If the facility accepts responsibility for enforcing restrictive law enforcement terms applied to a resident that are contrary to the Requirements for LTC Facilities, the facility would not be in compliance with federal long term care requirements. In addition, law enforcement jurisdictions may not be integrated with the operations of the facility.*

*While all portions of 42 CFR Part 483, Subpart B, apply to justice involved individuals, other areas where there may be concerns specific to this population are found at §483.12, F600, Abuse, Neglect, and Exploitation and §483.15(c), F622, Transfer and discharge. In such a case, surveyors should cite under the specific tag associated with the concern identified. For example, if there is a concern about a facility restricting visitors of a justice involved individual, cite such deficiency under §483.10(f)(4)(vi), F564, Resident Right to Visitors.*

*See Survey & Certification Memorandum 16-21-ALL dated May 3, 2016 (Revised 12/23/16) for additional guidance on justice involved individuals.*

***PROCEDURES §483.10(a)-(b)(1)&(2)***

*Deficient practices cited under Resident rights tags may also have negative psychosocial outcomes for the resident.* The survey team must consider the potential for both physical and psychosocial harm when determining the scope and severity of deficiencies related to dignity.

*Refer to the Psychosocial Outcome Severity Guide in Appendix P.*

*Surveyors shall make frequent observations on different shifts, units, floors or neighborhoods to watch interactions between and among residents and staff. If there are concerns that staff or others are not treating a resident with dignity or respect or are attempting to limit a resident’s autonomy or freedom of choice, follow-up as appropriate by interviewing the resident, family, or resident representative.*

* Observe if staff show respect for each resident and treat them as *an* individual.
* Do staff respond in a timely manner to the resident’s requests for assistance?
* Do *staff* explain to the resident what care *is being provided* or where they are taking the resident? *Is the resident’s appearance consistent with his or her preferences and in a manner that maintains his or her dignity*?
* *Do staff know the resident’s specific needs and preferences?*
* *Do staff make efforts to understand the preferences of those residents, who are not able to verbalize them, due to cognitive or physical limitations?*

Determine if staff members respond to residents with cognitive impairments *in a manner that facilitates communication and allows the resident the time to respond appropriately.* For example, a resident with dementia may be attempting to exit the building *with the intent* to meet her*/his* children at the school bus. *W*alking 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 reassure *the resident in a manner consistent with the requirements of 483.10(a) and (b)*.

*Examples of noncompliance may include, but are not limited to:*

* *A resident has not been treated equally as compared to others based on his or her diagnosis, severity of condition, or payment source.*
* *Prohibiting* a resident *from* participat*ing* in group activities *as a form of reprisal or discrimination. This includes prohibiting a resident from group activities without clinical justification or evaluation of the impact the resident’s participation has on the group.*
* *A resident’s rights, not addressed elsewhere (for example, religious expression, voting, or freedom of movement outside the facility in the absence of a legitimate clinical need) are impeded in some way by facility staff.*
* Requiring residents to seek approval to *post, communicate or* distribute information about the facility *(for example, social media, letters to the editor of a newspaper).*
* *Acting on behalf of the pertinent law enforcement or criminal justice supervisory authority by enforcing supervisory conditions or reporting violations of those conditions to officials for justice involved residents.*

***POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION***

For deficiencies regarding lack of visual privacy for a resident while that resident is receiving *treatment or* ADL care from staff in the bedroom, bathroom, or bathing room, *r*efer to §483.10(e), *F583*, Privacy and Confidentiality*.*

*For deficiencies regarding a resident’s lack of self-determination to make decisions about things that are important in his or her life, refer to §§483.10(f)(1)-(3), (8), F561, Self-determination.*

For deficiencies related to failure to keep residents’ faces, hands, *teeth,* fingernails, hair, and clothing clean, refer to *§483.24(a)(2), F677*, Activities of Daily Living (ADLs).

*If there are indications that a resident is in a secured/locked area without a clinical justification and/or placement is against the will of the resident, their family, and/or resident representative, review regulatory requirements at §483.12 and §483.12(a), F603, Involuntary Seclusion*.

**F551 *§483.10(b)(3)* In the case of a resident who has not been adjudged incompetent *by the state court, the resident has the right to designate a representative*, in accordance with State law and any legal surrogate *so* designated may exercise the resident’s rights to the extent provided by *s*tate law. *The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.***

***(i) The resident representative has the right to exercise the resident’s rights to the extent those rights are delegated to the representative.***

***(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.***

***§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.***

***§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.***

***§483.10(b)(6) If the facility has reason to believe that a resident representative is making***

***decisions or taking actions that are not in the best interests of a resident, the facility shall***

***report such concerns when and in the manner required under State law.***

***§483.10(b)(7)* In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident *devolve to and* are exercised by *the resident representative* appointed under State law to act on the resident’s behalf. *The court-appointed resident representative exercises the resident’s rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.***

***(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative’s authority.***

***(ii) The resident’s wishes and preferences must be considered in the exercise of rights by the representative.***

***(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.***

***DEFINITIONS §§483.10(b)(3)-(7) “Court of competent jurisdiction”*** *means any court with the authority to hear and determine a case or suit with the matter in question.*

***“Resident representative”*** *For purposes of this subpart, the term resident representative may mean any of the following:*

1. *An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;*
2. *A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or*
3. *Legal representative, as used in section 712 of the Older Americans Act; or*
4. *The court-appointed guardian or conservator of a resident.*
5. *Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.*

***GUIDANCE §§483.10(b)(3)-(7)***

When reference is made to “resident” in the *Guidance*, it also refers to any person who may, under State law, act on the resident’s behalf when the resident is unable to act for themselves. That person is referred to as the resident representative. If the resident has been formally declared incompetent by a court, the representative is who*m*ever the court appoints *(for example,* a guardian or conservator*)*.

A *competent* resident may wish to delegate decision-making to specific persons, or the resident and family may have agreed among themselves on a decision-making process. To the degree permitted by State law, the facility *staff* must respect the *delegated resident representative’s decisions regarding the* resident’s wishes and *preferences so long as the resident representative is acting within the scope of authority contemplated by the agreement authorizing the person to act as the resident’s representative*.

In the case of a resident who has been formally declared incompetent by a court, *a court appointed resident representative may be assigned. Facility staff must confer with the appointed resident representative.*

*State laws and court orders authorizing guardians, conservators, etc., vary considerably. Many statutes and court orders limit the scope of the authority of the representative to act on behalf of the resident.*

*Facility staff must obtain documentation that the resident’s* representative *has been delegated* the necessary authority *to exercise the resident’s rights and must* verify that a court-appointed representative has the necessary authority for the decision-making at issue *as determined by the court*. For example, a court-appointed *representative* might have the power to make financial decisions, but not health care decisions. *Additionally, the facility must make reasonable efforts to ensure that it has access to documentation of any change related to the delegation of rights, including a resident’s revocation of delegated rights, to ensure that the resident’s preferences, are being upheld.*

*Whether a resident has or has not been judged incompetent by a court of law, if it is determined that the resident understands the risks, benefits, and alternatives to proposed health care and expresses a preference, then the resident’s wishes should be considered to the degree practicable, including resident input into the care planning process.* The involvement of a representative does not relieve facility *staff* of *their* duty to protect and promote the resident’s interests. For example, a representative does not have the right to insist that a treatment be performed that is not medically appropriate *or* reject *a* treatment *that* may be subject to State law. *Surveyors must confirm delegation of resident rights to a resident representative. Surveyors must also determine, through interview and record reviews, whether or not the resident’s delegation of rights has been followed by facility staff.*

*If a resident’s representative is a same-sex spouse, he or she must be treated the same as an opposite-sex spouse with regard to exercising the resident’s rights. In Obergefell v. Hodges, 576 U.S.\_\_\_ (2015), the Supreme Court of the United States also ruled that all States must recognize*

*a marriage between two people of the same sex when their marriage was lawfully licensed and performed out-of-state.*

***PROCEDURES §483.10(b)(3)-(7)***

*Surveyors must check whether there has been a delegation of resident rights or designation of a resident representative. Surveyors must also determine, through interview and record reviews, whether or not the resident’s delegation of rights has been followed by facility staff.*

*Determine through interview and record review if the resident has been found to be legally incompetent by a court in accordance with state law.*

***If yes:***

* *Verify the appropriate legal documentation for a court-appointed resident representative is present in the resident’s medical record.*
* *Review court orders or other legal documentation to determine the extent of the court-appointed resident representative’s authority to make decision on behalf of the resident and any limitations on that authority that may have been ordered by the court.*
* *Determine if the court-appointed representative is making decisions for the resident beyond the scope of the resident representative’s decision-making authority and the facility is relying on that authority as the basis of a practice (e.g., health care treatment, managing resident funds, discharge decision). If so, a deficiency may be cited under this regulation.*
* *Determine if the resident was involved in care planning activities and able to make choices, to the extent possible.*
* *Observe resident care and daily activities (e.g., participation in activities) for adherence to resident’s or court-appointed resident representative’s goals, choices, and preferences. Even when there is a court-appointed resident representative, the facility should seek to understand the resident’s goals, choices, and preferences and have honored them to the extent legally possible.*

***If no:***

* *Determine how decisions are being made for the resident. Does the resident maintain all of his/her rights, even if he/she has designated a representative to assist with decision-making unless a court has limited those rights under state law, and only to the extent that has been specified by a court under state law? Has the resident designated a resident representative and is facility staff respecting the authority of this designate surrogate decision-maker to act on behalf of the resident?*
* *Are all residents informed of their plan of care or treatment in the most understandable manner possible, and given an opportunity to voice their views? Autonomy is also expressed through gestures and actions and this also should be recognized. Residents even without capacity or declared incompetent may be able to express their needs and desires.*
* *Determine whether same-sex spouses are treated in the same manner as an opposite-sex spouse in all states and territories.*
* *If the resident has delegated a resident representative, verify the appropriate documentation is present in the resident’s medical record.*

***KEY ELEMENTS OF NONCOMPLIANCE §§483.10(b)(3)-(7)***

*To cite deficient practice at F551, the surveyor’s investigation will generally show that the facility failed to do any one or more of the following:*

* *Ensure a competent resident’s choice for a representative is honored* ***or***
* *Ensure that treatment of a same-sex spouse was the same as treatment of an opposite-sex spouse;* ***or***
* *Ensure the resident representative did not make decisions beyond the extent allowed by the court or delegated by the resident;* ***or***
* *Ensure the resident’s wishes and preferences were considered when decisions were made by the resident representative;* ***or***
* *Ensure the decisions of the resident representative are given the same consideration as if the resident made the decision themselves;* ***or***
* *Honor the resident’s authority to exercise his or her rights, even when he or she has delegated those rights, including the right to revoke a delegation of rights;* ***or***
* *Ensure the resident representative was reported as State law required when not acting in the best interest of the resident;* ***or***
* *Ensure a resident who was found incompetent by the court is provided with opportunities to participate in the care planning process.*

*Facility leadership must be aware of the culture that exists in its facility and may use various methods to assess the attitudes and values prevalent amongst staff. These methods include, reviewing complaints or grievances, which could reasonably impact a resident’s quality of life, or allegations of abuse, neglect or mistreatment. In order to identify whether staff supports each resident’s quality of life, leadership should observe and evaluate verbal and nonverbal interactions between staff and residents. Negative observations could include staff actions such as the following:*

* *Verbalizing negative or condescending remarks, or refusing to provide individualized care to a resident due to his/her age, race, or cognitive or physical impairments, his/her political or cultural beliefs, or sexual preferences;*
* *Dehumanizing an individual through verbal and nonverbal actions such as talking to others over a resident without acknowledging his/her presence, treating the resident as if he/she were an object rather than a human being, mistreating, or physically, sexually or mentally abusing a resident.*

*These types of staff actions and attitudes do not recognize nor value the individual. An individual’s life experiences, values, needs, choices and relationships must not be diminished, to the extent possible, due to admission to a nursing home. Treating a nursing home resident in any manner that does not uphold a resident’s sense of self-worth, dignity and individuality dehumanizes the resident and creates an environment that perpetuates an unhealthy, unsafe attitude towards the resident(s).*

*In order to achieve a culture and environment that supports quality of life, the facility must ensure that all staff, across all shifts and departments,, understand the principles of quality of life, and honor and support these principles for each resident and that the care and services that are provided by the facility are person-centered, and honor and support each resident’s preferences, choices, values and beliefs.*

***The Link between Noncompliance at other Regulatory Tags and Noncompliance at Quality of Life***

*Quality of Life at F675 should not automatically be cited when noncompliance has been identified in Resident’s Rights/Quality of Care/Abuse-Neglect or other regulatory tags, unless the cumulative effect of the noncompliance creates an environment that reflects a complete disregard of one or more residents’ well-being, and rises to the level of Immediate Jeopardy.*

*See below for an example of noncompliance at F675 demonstrating the cumulative effect of noncompliance at other tags for multiple residents:*

*The facility failed to provide an environment which supported and enhanced each*

*resident’s quality of life, which was the result of the cumulative effect of noncompliance*

*cited at dignity, abuse, staffing, and continence care. This noncompliance was found to*

*be pervasive and created an environment reflecting a complete disregard of one or more*

*residents’ well-being and quality of life, which has caused or is likely to cause serious*

*harm related to one or more residents’ self-worth, self-esteem, and well-being.*

*A complaint investigation revealed facility staff members posted unauthorized videos and photographs on social media of several residents during bathing, going to the bathroom, and grooming, including nude photos and photos of genitalia. As a result, the residents suffered public humiliation and dehumanization. Facility staff interviewed were aware of this abuse, but did not report to administration due to fear of retaliation by the perpetrators and fear of losing their jobs.*

*During a resident council meeting, several residents reported that they heard staff describing the photos, laughing about the postings and had seen staff passing around cell phones. As a result, the residents stated that they were afraid to take a shower or bath, and extremely uncomfortable when requesting assistance to go to the bathroom because they thought it might happen to them, and that they had shared these concerns with other resident’s in the facility. (Refer to noncompliance cited at 483.12, F600 – Abuse) When discussing going to the bathroom, the residents stated that in addition to being afraid of asking for help, when they did, there were not enough staff to answer call lights. They said that staff would ignore their call light, walk by or would answer the light and leave without assisting the residents. This had resulted in episodes of incontinence of urine and feces, which they stated was extremely embarrassing, humiliating and degrading to them. (Refer to noncompliance cited at 483.10(a)(1), F550 – Dignity; 483.35, F725 – Insufficient Staff, Nursing Services; and 483.25(e)(1), F690 – Incontinence, Quality of Care.)*

*Several residents stated that they were afraid to ask for staff assistance for the need to use the bathroom, based on their fear related to the postings on social media. In addition, they stated that when they were receiving care, if staff pulled out a cell phone, they didn’t know if staff were taking and posting pictures of them. When asked if these concerns had been reported to the administration, the residents stated that they identified the issue with the call lights and not enough staff multiple times during council meetings, but that the administration only said, we will look into it, and nothing was done. They said they were afraid to report the cell phone concerns. One resident said that an aide told him/her that if they didn’t quit complaining to the administrator, no one would help them and they would be transferred to another facility. When the resident began to cry, the aide laughed and walked out of the room, verbally taunting him/her for crying.*

*See below for an example of noncompliance at F675 demonstrating the cumulative effect of noncompliance at other tags for one resident:*

*The facility failed to provide an environment which supported one resident’s quality of life, which was the result of the cumulative effect of noncompliance cited at 483.10(a), Dignity, and 483.10(b)(2), Freedom from discrimination, F550; 483.12(a) Abuse; 483.10(h), Personal Privacy – F583; 483.10(f), Self-Determination -F561; 483.21(b), Comprehensive, Person-Centered Care Planning -F656; and 483.60(c)(4), Menus and Nutritional Adequacy – F803. This complete disregard of the residents’ quality of life, caused serious harm related to her self-worth, self-esteem, and well-being.*

*The surveyor identified a resident who was admitted 6 weeks ago, and had religious beliefs which differed from the resident population in the nursing home, and those of the staff. During interviews, the resident and her family reported that staff continually made derogatory remarks about the resident’s culture/religion to each other within earshot of the resident, or while in the room providing ADL care to the resident. This occurred during all shifts. Additionally, the resident reported that discriminatory remarks were made by housekeeping and dietary staff as well. The resident’s family reported this was particularly worse on weekends when facility leadership were not in the building. The family members reported they would take turns visiting the resident on weekends, to support the resident and assist with her care. When asked if this was reported to facility management, the resident said her family had reported it to the Administrator on several occasions, but that nothing had changed. Interview with the Administrator revealed that an in-service was planned for the future. (Refer to noncompliance cited at 483.10(a)(1), Dignity, and 483.10(b)(2) Freedom from Discrimination -F550, 483.12(a), Abuse – F600)*

*The resident described frequent occurrences of disregard of her personal privacy including not covering her body completely, allowing full view of her arms, legs and buttocks when transporting her to the shower. The surveyor observed, on one occasion, staff not pulling the privacy curtain when assisting her to dress, resulting in anyone walking in the hallway being able to view her as she was dressed. (Refer to noncompliance cited at 483.10(h), Personal Privacy – F583)*

*On multiple occasions, the resident reported that she was assigned a male care giver, which is against her religious belief that a person of the opposite sex cannot provide care. On these occasions, the resident would tearfully refuse to get dressed, or call her family to assist her. On at least one occasion, the resident was forced to receive a shower with the assistance of a male aide, which resulted in the resident crying uncontrollably until her family arrived. Progress notes in her medical record noted this occasion as the resident becoming uncontrollable while receiving a shower. Additionally, when dressing her for the day, staff would not cover her hair, arms and legs, and would say that her scarf was missing, only to be found when her family arrived. On interview, staff said they were unaware that this was a violation of her religion. This noncompliance resulted in the resident frequently refusing to shower, or, according to family, calling her family, begging for them to come get her dressed. (Refer to noncompliance cited at 483.10(f), Self-Determination -F561.)*

*The surveyor observed the meal tray set up and found it did not honor the resident’s preferences identified on the meal tray card and care plan. The resident reported that this happened on most days, and even if she requested an alternative, she would be given a food item that was prohibited according to her religion, and therefore, she would not eat that meal. The resident’s family stated that they frequently brought food in to the resident because she could not eat what was brought to her.*

*On interview, dietary staff stated they did not have the time to prepare a special diet for this one resident, and stated to the surveyor, “They should have thought of that before they came to this country.” Additionally, the dietary staff reported that he/she was not aware of the dietary requirements of this resident’s religion. An interview with the consulting dietitian revealed that he/she was not aware that this resident had been admitted to the facility, and she agreed that the menu did not meet this resident’s religious preferences. (Refer to noncompliance cited at 483.60(c)(4), Menus and Nutritional Adequacy – F803)*

*Review of the resident’s care plans revealed that there was no identification of this resident’s preferences or dietary requirements related to her religion. (Refer to noncompliance cited at 483.21(b), Comprehensive, Person-Centered Care Plan – F656*

*As the result of cumulative effect of the noncompliance identified, this resident suffered loss of religious and cultural identity, had ongoing feelings of extreme sadness and humiliation, and expressed a wish to die.*

* *Facility staff are not able to demonstrate their response and rationale to grievances;*
* *Facility staff prevent family members or representatives from meeting with those of another resident.*

***POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION***

*For concerns regarding the handling of individual grievances, refer to §483.10(j), F585, Grievances.*