

## **F248**

### **§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.<sup>1</sup>

#### **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.<sup>2</sup>

#### 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.<sup>3</sup> 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.<sup>4</sup>

For more information on activities in homes changing to a resident-directed culture, the following websites are available as resources: [www.pioneernetwork.net](http://www.pioneernetwork.net); [www.culturechangenow.com](http://www.culturechangenow.com); [www.qualitypartnersri.org](http://www.qualitypartnersri.org) (click on nursing homes); and [www.edenalt.com](http://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.<sup>5</sup>

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.<sup>6</sup> 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.<sup>7</sup> 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.<sup>8</sup> In addition to the activities component of the comprehensive care plan, information may also be found in a separate activity plan, on a CNA flow sheet, in a progress note, etc.

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

**NOTE:** For residents with no discernable response, service provision is still expected and may include one-to-one activities such as talking to the resident, reading to the resident about prior interests, or applying lotion while stroking the resident's hands or feet.

Activities can occur at any time, are not limited to formal activities being provided only by activities staff, and can include activities provided by other facility staff, volunteers, visitors, residents, and family members. All relevant departments should collaborate to develop and implement an individualized activities program for each resident.

Some medications, such as diuretics, or conditions such as pain, incontinence, etc. may affect the resident's participation in activities. Therefore, additional steps may be needed to facilitate the resident's participation in activities, such as:

- If not contraindicated, timing the administration of medications, to the extent possible, to avoid interfering with the resident's ability to participate or to remain at a scheduled activity; or
- If not contraindicated, modifying the administration time of pain medication to allow the medication to take effect prior to an activity the resident enjoys. The care plan should also identify the discipline(s) that will carry out the approaches. For example:
  - Notifying residents of preferred activities;
  - Transporting residents who need assistance to and from activities (including indoor, outdoor, and outings);
  - Providing needed functional assistance (such as toileting and eating assistance); and
  - Providing needed supplies or adaptations, such as obtaining and returning audio books, setting up adaptive equipment, etc.

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

- A continuation of life roles, consistent with resident preferences and functional capacity (e.g., to continue work or hobbies such as cooking, table setting, repairing small appliances);
- Encouraging and supporting the development of new interests, hobbies, and skills (e.g., training on using the Internet); and
- Connecting with the community, such as places of worship, veterans' groups, volunteer groups, support groups, wellness groups, athletic or educational connections (via outings or invitations to outside groups to visit the facility).

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

- Altering a therapy or a bath/shower schedule to make it possible for a resident to attend a desired activity that occurs at the same time as the therapy session or bath;
- Assisting residents, as needed, to get to and participate in desired activities (e.g., dressing, toileting, transportation);
- Providing supplies (e.g., books/magazines, music, craft projects, cards, sorting materials) for activities, and assistance when needed, for residents' use (e.g., during weekends, nights, holidays, evenings, or when the activities staff are unavailable); and
- Providing a late breakfast to allow a resident to continue a lifelong pattern of attending religious services before eating.

## **INTERVENTIONS**

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

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

When evaluating the provision of activities, it is important for the surveyor to identify whether the resident has conditions and/or issues for which staff should have provided adaptations. Examples of adaptations for specific conditions include, but are not limited to the following:

- For the resident with visual impairments: higher levels of lighting without glare; magnifying glasses, light-filtering lenses, telescopic glasses; use of "clock method" to describe where items

are located; description of sizes, shapes, colors; large print items including playing cards, newsprint, books; audio books;

- For the resident with hearing impairments: small group activities; placement of resident near speaker/activity leader; use of amplifiers or headphones; decreased background noise; written instructions; use of gestures or sign language to enhance verbal communication; adapted TV (closed captioning, magnified screen, earphones);
- For the resident who has physical limitations, the use of adaptive equipment, proper seating and positioning, placement of supplies and materials<sup>12</sup> (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<sup>13</sup>;
- 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.