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Regulating "Culture Change" in Long-term Care

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Running head: REGULATING "CULTURE CHANGE" IN LONG-TERM CARE

Regulating "Culture Change" in Long-term Care

Abstract

As an institutional type, nursing homes can be most closely linked to the hospitals created during the Industrial era of our nation's history, and have adopted similar approaches to providing clinical care. While often physically and cognitively frail the needs of nursing home residents are more complex than simply needing medical treatment. These individuals often become permanent residents of these facilities and require a setting that recognizes them as individuals. As America ages, projections point to an increasing use of nursing homes in the next ten to twenty years. Therefore, nursing homes will become an increasingly important place-type in our country. Since 1997, groups increasingly called for more patient-centered approaches. In the field of long-term care, this is often referred to as "culture change." The goal of culture change is to create a system of "interdependency" that enhances the quality of life for residents as well as the quality of the work environment for staff. This approach focuses on the capacity of residents and their abilities to participate fully in the lives and the decision about their daily routines and care. This type of care requires rethinking the way that residents interact with care professionals as well as the built environment. Finding a fit between these new approaches and existing regulatory requirements is daunting. Nursing homes derive a majority of their resources from federal dollars, and eligibility is contingent upon meeting federal regulatory policies. The existing regulatory statutes may be too clinically focused to provide for the necessary flexibility that is required in a person-centered care approach. Some argue that "negative attributes of nursing home culture are reinforced by governmental regulation and payment mechanisms, as part of a mutually-reinforcing and mutually-symbiotic relationship between government and the nursing home industry (Vladeck, 2003, p. 3)." This paper will focus on understanding of the existing regulatory framework and the implications and contradictions of the new interpretive guidelines that are intended to advance the quality of life in long-term care settings. It will conclude with recommended actions to increase the efforts to ensure that long-term care regulations make quality of life a top priority.

Keywords: Nursing Homes, Regulations, Policy, Quality of Life, Gerontology

Regulating "Culture Change" into Long-Term Care

As an institutional type, nursing homes can be most closely linked to the hospitals created during the Industrial era of our nation's history (Haber & Gratton, 1994). Today there are still hundreds of nursing homes across the country structured around this medical model even as a majority of residing elders receive very little health care (Vladek, 2003; Meyer, 2006; Lustbader, 2001). In response to a growing consumer demand for changes in health care, the Institute on Medicine (IOM) has identified patient-centered (or person-centered) approaches as essential for achieving the quality of care desired by Americans (Talerico, O'Brien & Swafford, 2003, p. 12). In long-term care, the term "culture change" is often used simultaneously with person-centered initiatives referring to a *social model* of care. This model calls for transformed physical environments, radically revised staff configurations, and a shift in the organizational philosophy of the nursing home setting (Rabig, et al., 2006, p. 533; Shields & Norton, 2006; Kane, Lum, Cutler, Degenholtz, & Yu, 2007; Lustbader, 2001).

Finding a fit between these new approaches and existing regulatory requirements has created a daunting challenge for providers. There are concerns, about costs, adherence to regulations, regulatory interpretations and maintenance of quality of care. Nursing homes derive almost 75% of their income through Medicaid and Medicare, and eligibility for these federal dollars is contingent upon adopting and complying with federal regulatory policies (Hovey, 2000). Although there is an increasingly visible response from regulatory bodies to provide interpretation and guidance in meeting requirements (CMS, 2006; CMS, 2009b), the existing regulatory statutes may, however, be too clinically focused to provide for the necessary flexibility that is required in a person-centered care approach. Some argue that "negative attributes of nursing home culture are reinforced by governmental regulation and payment mechanisms, as part of a mutually-reinforcing and mutually-symbiotic relationship between government and the nursing home industry (Vladeck, 2003, p. 3)."

Rosalie Kane, researcher and policy advocate for long-term care, notes, "despite widespread beliefs among lay and professional people alike that life in nursing homes is miserable, quality of life hardly makes it to the political and policy radar screen (2003, p. 28)." The problem is complex and tied to both specific aspects prescribed in the statutes as well as well as the fundamental conceptual framework of how regulations are structured and

implemented. This paper will focus on understanding of the existing regulatory framework and the implications and contradictions of the new interpretive guidelines that are intended to advance the quality of life in long-term care settings. It will conclude with recommendations for actions that can be taken by CMS to increase the efforts to ensure that long-term care providers are doing more to ensure that quality of life is a top priority.

Dependency: the Epidemiological Aspect of this Problem

A Growing Senior Population:

It is well established that America is growing older[1]. Since disability rates rise with age, there is a strong likelihood that this aging population will bring with it increased numbers of disabled persons. As a major advocacy group for adults over 50, AARP (2005) has stated that "people 50+ should have independence, choice, and control in ways that are affordable for them and society." This goal includes those who may find themselves residing in nursing homes. The explicit identification of "*independence, choice, and control*" is precisely the opposite image that we have of nursing homes that are based on their assumptions of dependency and incapacity. With a burgeoning senior population, we can anticipate increases, or at the very least, sustained need for long-term care settings. Exhibit 1 demonstrates the percentages of those 65+ who experience functional limitations including those in care facilities.

More than 1.6 million Americans live in nursing homes, most of them elderly, frail, poor, and vulnerable. While the percentages of elders residing in long-term care institutions has slightly declined (from 6% to 4% from 1992 to 2005), the overall growth rate of older adults will be on the rise in the next 20 – 30 years (see Exhibit 2). The longer an individual lives, the greater likelihood that individual will spend some time in a nursing home, and length of use has also been positively correlated with end of life (Spillman & Lubitz, 2002). With the projections on aging and longevity, nursing home use is likely to begin to increase in the next 10 -20 years (See Exhibit 3). More than half those younger than age 90 who enter a NH will spend a year or more there, and for most ages, approximately 20% will spend five years or more (Spillman & Lubitz, p, 970).

[1] Federal Interagency Forum on Aging-related Statistics. *Older Americans 2008: Key Indicators of Well-being. Federal Interagency Forum on Aging-Related Statistics*. Washington, DC: U.S. Government Printing Office. March 2008.

How They are Affected

The prevailing assumption of nursing homes is to generalize that "the old people who live there" are totally dependent and, therefore, their lives are of less value (Baltes, 1996, p. 14; Kane, 2003, p. 29). Dependency is an epidemiological concept that can be related to health (Baltes, 1996, p. 14) as well as quality of life (Lustbader, 1991). There are multiple causes of dependency; it cannot be associated merely with biological status, but is influenced strongly by social-environmental conditions as well (Baltes, 1996, p. 9). Lustbader's (1991; 2001) work has focused on the general concept of "captive dependency." Decline in functional health status and a depletion of financial resources will often relegate many frail elders to institutional care; care that will further reduce their sense of autonomy and self-efficacy. Coupled with the de-humanizing conditions in many nursing homes, it is a further attack on the individual and societal expectations for quality of life in general, sometimes referred to as psychologically toxic. Environments that impose multiple forms of dependencies on elders, therefore, exacerbate their condition[2]. In nursing homes, structures have be imposed that enable physical dependencies related to activities of daily living (ADLs) and these can lead to behavioral dependencies related to learned helplessness and learned dependency (Baltes, 1996, p. 18).

Dependency in nursing homes has been systematically measured. A study by Harrington and Carillo (1999) investigated resident health status outcomes for all reporting nursing homes between 1991 – 1997. Their findings demonstrate that average dependency scores for physical status increased (showing a decline in independence) between these dates (p. 475). While subsequent follow-up data has not been provided, these outcomes were collected to assess the impact of federally mandated assessments of resident health status. In light of the other demographic factors (increases in older adults and prevalence of frailty upon admission to nursing homes), it is reasonable to suspect that nursing home residents are still subjected to an environment that focuses on their limitations rather than their remaining capacities. While the effects of dependency on quality of life are difficult to empirically measure, there is documented salience of the relationships among functional competence, meaningful activities, relationships and dignity (all domains that can individually or collectively contribute to dependency) to quality of life in nursing homes (Kane, 2001; Kane, 2003; Kane et al., 2003).

[2] Lawton and Nahemow's (1973) Ecological Model of Competence Press provide a theoretical construct of the relationships between an individual's abilities and the environment they are trying to negotiate.

What's Different about Culture Change?

The goal of culture change is to create a system of "interdependency" that enhances the quality of life for residents as well as the quality of the work environment for staff (Shields & Norton, 2006; Rahman & Schnelle; 2008, Baltes, 1996, p. 11). This approach focuses on the capacity of residents and their abilities to participate fully in the lives and the decision about their daily routines and care. This type of care requires changes on several dimensions. One fundamental change is in the way that residents interact with care professionals as well as the built environment (Grant & Norton, 2003; Rabig, et al., 2006). Staff members from all functional areas are sometimes grouped into self-directed teams and are dedicated to a specific group of elders within a defined physical location, now referred to as a "household." The emphasis is now more on effectiveness of the services that influence the perceptions of quality of both the care delivered and the life lived within the setting. Initial evaluations on early models of culture change demonstrate that a supportive environment appears to be critical for culture change practices (Kane, Lum, Cutler, Degenholtz, & Yu, 2007, p. 832; Rabig et al., 2006, p. 354; Pekkarinen, Sinervo Perala & Elovainio, 2004, p. 638).

Policy Enactment:

A Brief History of "Protective" Regulations

To understand how policy structures for nursing homes should change to reflect a priority on interdependence and the value of quality of life, it is necessary to look back and understand how nursing home policy has evolved. Public and governmental concerns about quality of care in nursing homes[3] can be traced back at least to the 1950s. Before the establishment of Medicare and Medicaid in 1965 there were essentially no federal standards regulating nursing homes; regulation was left up to the states, and the standards varied widely (Walshe, 2001, p. 219). After the passage of Medicare and Medicaid, many nursing facilities evolved during the 1970's and 1980's to morph themselves (physically and organizationally) into health care based organizations that could take advantage of these reimbursement structures (Schwartz, 1996). Reimbursements were based primarily on "medical needs," however, and other aspects of care were labeled as "social" or "supportive" and thus of a lower priority (p. 33).

[3] This statement refers to settings that represent the origins of our contemporary institutions and doesn't intend to address the previous history of the almshouses.

In 1986, the Committee on Nursing Home Regulation of the Institute of Medicine (IOM) issued a landmark report recognizing quality of life as an important dimension in the quality of care (Vladeck, 2003, p. 4). This report resulted in the subsequent implementation of the Omnibus Budget Reconciliation Standards Act (OBRA) '87 that ushered in an opportunity to broaden the enforcement of quality measures for elders residing in skilled nursing facilities. OBRA '87 stipulated standards for facilities receiving federal funding by requiring a systematic and uniform assessment of all residents based on a standard instrument, called the Minimum Data Set (MDS). These regulations are implemented by states but overseen by the Centers for Medicare and Medicaid Services (CMS) (Walshe, 2001, p. 12). When these laws first went into effect, representatives from the National Coalition for Nursing Home Reform believed these would be useful tools providing tangible evidence that the care is making a difference (Cotton, 1993, p2337). Quality of life is still not a dimension that is clearly articulated through specific measures in the regulatory oversight process.

Changes to the Medicare policies in the early 1990's compounded this problem of "medicalizing" nursing homes with the development of a highly profitable market for "sub-acute" services. Many nursing homes took advantage of these changes to the reimbursement structures to obtain resources in order to improve amenities in rehabilitation and physical therapy equipment and physical settings of these institutions. The needs of these sub-acute patients were clinical and the care medically driven, however, and the types of "improvements" that were made followed clinical strategies. The focus on services drove the acquisition of resources, therefore, the "home" aspects of nursing homes and the emphasis on quality of life measurements for elders was lost (or at least diminished) in the overall picture once again (Vladeck, 2003, p. 4).

The Intersection of Regulations and Quality of Life

What exactly we are looking for in nursing home outcomes have yet to be agreed upon, or even really discussed at a serious level. The goal of the OBRBA regulations was that facilities would focus on the highest practical well-being of the resident. There is little evidence, however that the current systems reward high quality person-centered care (Talerico, O'Brien & Swafford, 2003, p. 14). Walshe (2001) notes that many of same quality problems that spurred calls for greater regulation in the 1970's and 1980's are still endemic in many of our nursing

homes today (p. 128). Research investigating the relationships between regulation and quality of life has been receiving increased attention for over the past 15 years (Cotton, 1993; Cohen-Mansfield, et al., 1995; Hovey, 2000; Kane, 2003; Kane, et al., 2003; Kane, Lum, Cutler, Degenholtz & Yu, 2007; Walshe, 2001, p. 129). Specific items related to conflicts between quality of life and regulatory requirements include scheduling, food portions, and mandated features of the physical environment. For example, Cohen-Mansfield et al. (1995) cite examples from states with requirements that all residents are to attend all meals and that no more than 14 hours pass between dinner and breakfast. This type of regulation results in some residents being awakened as early as 5:00 a.m. in order to make it to breakfast at 7:30, interfering with sleep and choice to "sleep-in". Other examples include prescribed food portions without consideration of residents' food preferences or previous eating habits. Features of the built environment are also prescribed without consideration to the functional limitations of frail elders or their ability to negotiate some spaces (e.g. heavy doors, window heights, limited square-footage requirements).

One thing that is clear is that dependency and loss of autonomy diminishes quality of life, and nursing homes can do more to apply a full range of efforts that could have a positive impact. In order to achieve these aims, however, nursing homes must be empowered by the regulatory environment to creatively address the diverse needs of their residents (Walshe, 2001). Compliance with regulations and fit with the aims of culture change are beginning to be addressed at the federal level with CMS providing more detailed interpretation of the State Operations Manual (SOM) (Centers, for Medicare & Medicaid Services, 2006). These are important first steps in the process. If people do require long-term care, they want the same things that other people want; as much activity to one's taste as possible; freedom to do what they choose where and when they choose it; comfort and companionship with one's family and friends; and a safe environment (Wilkerson & MacDonell, 2003, p. 382). Institutional notions of safety at any cost, quantity over quality of life, and the convenience of uniformity in an institution have taken precedence over these features of personal preference (Kane, 2001). "Culture change entails the building of new beliefs, values, and meanings on the platform of old ones. It also involves the change of behaviors, habits, language, and rituals. The enterprise of quality oversight should both reflect the ambient culture and accepted quality standards, and also push the field toward new ones in the interest of the elders served. (Wilkerson & MacDonell,

2003, p. 393):" We must find a way to create a regulatory structure that balances between security and autonomy, quality of care and quality of life.

Policy Assessment:

Revisions to Interpretive Guidelines Issues by CMS

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government (U.S. GPO, n.d.). Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements of 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid Programs (CMS, 2009). On April 10, 2009, the Director of the Centers for Medicare and Medicaid issued a memorandum (Ref: S&C-09-31) to State Survey Agency Directors providing new interpretive guidelines for these regulatory statutes. These guidelines become an official component of the regulatory language, and state surveyors will be required to apply these new interpretations beginning June 17, 2009.

The significance of these interpretative guides is that most specifically address quality of life issues as mandated in the State Operations Manual (SOM) Appendix P – Survey Protocols for Long Term Care Facilities – Part I, Sub-Task 5D – Quality of Life Assessment. Items 42 CFR 483.15, Quality of Life; and 42 CFS 483.70, Physical Environment is covered in detail with a broadened set of examples of quality indicators that surveyors are to consider. These interpretive guidelines are designed to assist state surveyors in understanding "what" to look for in a skilled care setting, but more importantly to a culture change environment, how to not penalize a facility for their attempts to respect residents' preferences, while simultaneously protecting their safety and quality of care. Highlighted below are those interpretive changes that most specifically address resident autonomy and quality of life. The implications for further revisions to the regulatory language will be then be discussed in the closing section.

The interpretive guidelines for item 483.15(a) Dignity; that specifically address dimensions impacting the quality of life are demonstrated in Exhibit 4. The nature of this language supports draws attention to the built environment as well as the policies by which staff are expected to abide. Another implication of this guideline addressing dignity is the nature of the dining room environment and the furnishings that are used. If bibs are to be avoided, semi-

circular “feeder-tables” that accommodate up to four residents who can be “fed” by a single staff member should not be considered dignified either.

Another key change is in the item 483.15(b) Self-Determination and Participation. As shown in Exhibit 5, the nature of this language again suggests that attention is paid to the built environment as well as the staff routines. Implications for environmental support are alluded to but not specifically stated, however. Many facilities focus on activities programs that are group based, but have little ability to support or encourage individual hobbies. Space allocation within the building is a key dimension to this requirement. There are few examples of buildings that provide for this flexibility. The relationship to section 483.70 (g), “Dining and resident activities” in the SOM is not made clear.

Accommodation of Needs, item 483.15(e) has substantial revisions. Changes specifically addressing quality of life through resident autonomy are demonstrated in Exhibits 6a and 6b. The revisions to the Accommodation of Need section demonstrate the significant role that the built environment “should” be playing in supporting the lives of residents. As currently stated, the staff are simply expected to be an extension of the setting. This is burdensome and of limited impact when surveyors are not around. Expectations for features of the setting as well as the furniture and equipment within these spaces should be more clearly articulated within section 483.70 of the SOM that specifies criteria for the environment.

Exhibit 7 outlines those revisions to the interpretive guidelines that specifically address the environment. The expansion of characteristics and qualities of the setting give additional emphasis to the original languages that stipulates “home-like” environment. This draws increased attention to the environmental milieu and the role of the physical setting in supporting quality of life for residents. A fact that has been a topic of researchers for a number of years (e.g. Lustbader, 2001; Grant & Norton, 2003; Kane, et al., 2007). These interpretations are clearly in response to many of the culture change households that have become much more prevalent across the country. If this is the type of environment that is desired, then these expectations need to be shared with building code officials, interior designers, architects, and systems engineers who are called upon to plan and design these spaces.

One specific example of this is the minimum space requirements as stipulated Under Title 42 par 483 subpart b – 483.70 Physical Environment, item (d) Resident rooms. This item states the “*Resident rooms must be designed and equipped for adequate nursing care, comfort,*

and privacy for residents" (U.S. GPO, n.d.). Facilities are permitted, however, to provide as little as 80 square feet per resident is a multi-bedded room (as stipulated in (d)(1)(ii)) and this room can accommodate up to four residents (as stipulated in (d)(1)(i)). Private rooms can be designed as small as 100 square feet in a single resident room (as stipulated in (d)(1)(ii)). These minimums are not adequate space for residents to negotiate and leave only one location for the position of a bed which restricts resident choice. These close proximities also do not protect the privacy of conversations (as stipulated in (d)(1)(iv)) including personal care conversations as protected by HIPPA, especially in a 4 bedded room situation. A related item (e) still permits facilities to design resident rooms without direct access to their private toilet; they merely need to be "near" the room. These "acceptable" standards do not reflect the nature of the language as presented in the interpretive guidelines.

Proposal Development:

Recommended Actions and Further Changes to Title 42, Code of Federal Regulations

If we come full circle and re-consider framework of the nursing home as an institutional type, we can propose that a new framework would be more fitting. Shedding the constraints of the medical model and focusing on the social dimensions of life would allow for the construction of buildings that support frail elders as they simultaneously receive necessary care. The recent interpretive changes are an important step forward in finding a fit between these new approaches and existing regulatory requirements, but the time has come for us to go beyond the simply prescribing indicators and move into more specific environmental changes that support the desired behaviors that we claim we value.

Based on the Interpretive Guidelines Issues by CMS, three key actions would be effective to this aim. First, there must be a stronger link the quality of life dimensions stated in the survey process and the expectations of the design of the physical environment. For example, there should be an increase in the minimum requirements for resident rooms to ensure residents have a setting that provides for and supports their autonomy, privacy, and dignity in a way that can actually be achieved through the space and amenities provided. Second, design guidelines need to be developed for design professionals similar to the training materials for surveyors. The indicators sought in the survey process are tractable artifacts that can be provided through the

environment, its contents as well as the behaviors that are enacted within the spaces. Design professionals can be partners in creating settings that support quality of life if they have a better idea of those "evidences" that are important in the survey process. Third, CMS should encourage and support continued research into the patterns of life and the routines that support a homelike environment. Physical Environment tags are based on the residents' perception of homelike. We must continue to learn more about those aspects of the environmental milieu that create these experiences. Continued evolution of the federal statutes to reflect the nature of the environment will truly give residents autonomy and dignity as well as support staff in their pursuit of providing quality care.

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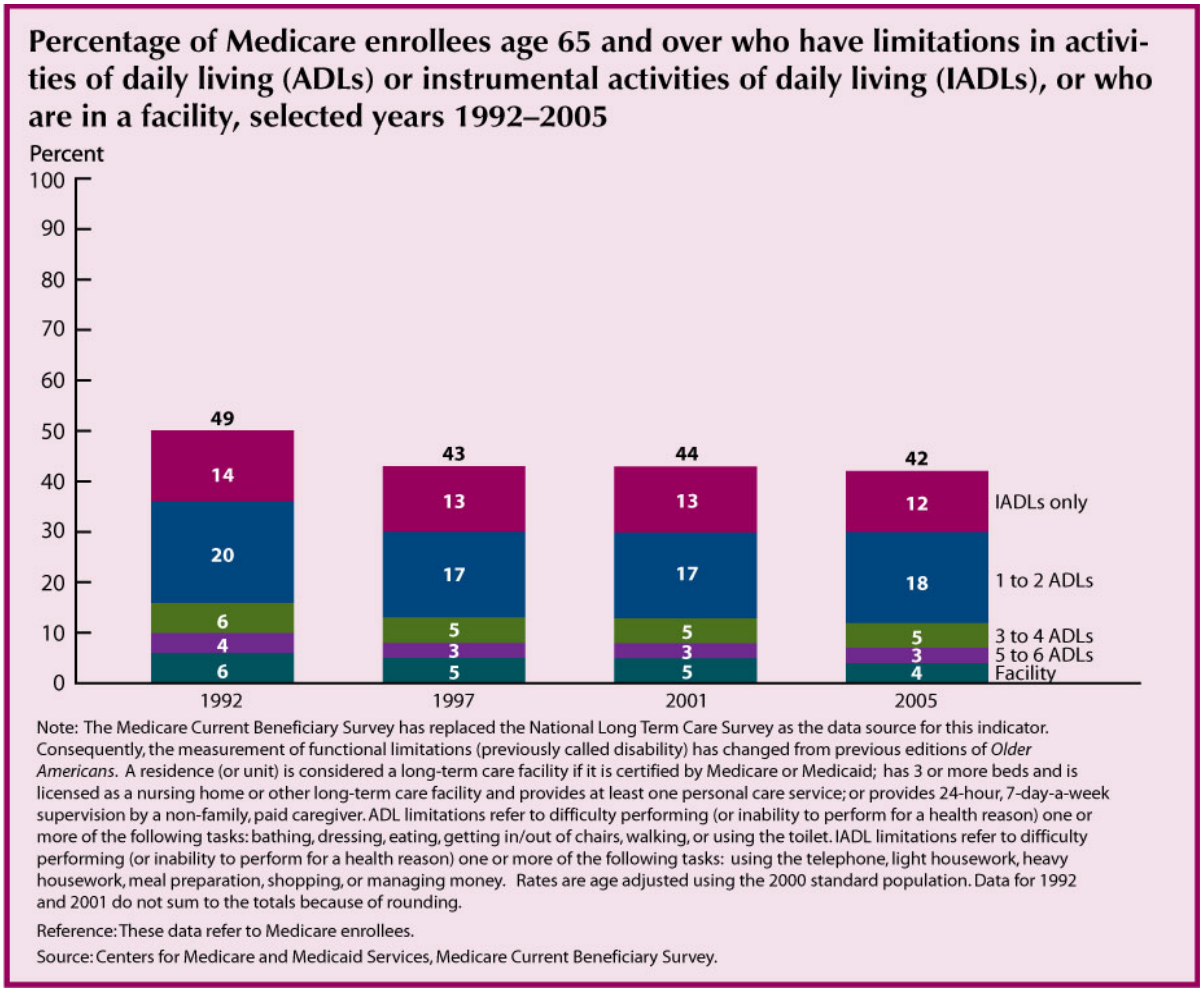

Exhibit 1: Table from Federal Interagency Forum on Aging-related Statistics. *Older Americans 2008: Key Indicators of Well-being. Federal Interagency Forum on Aging-Related Statistics.*

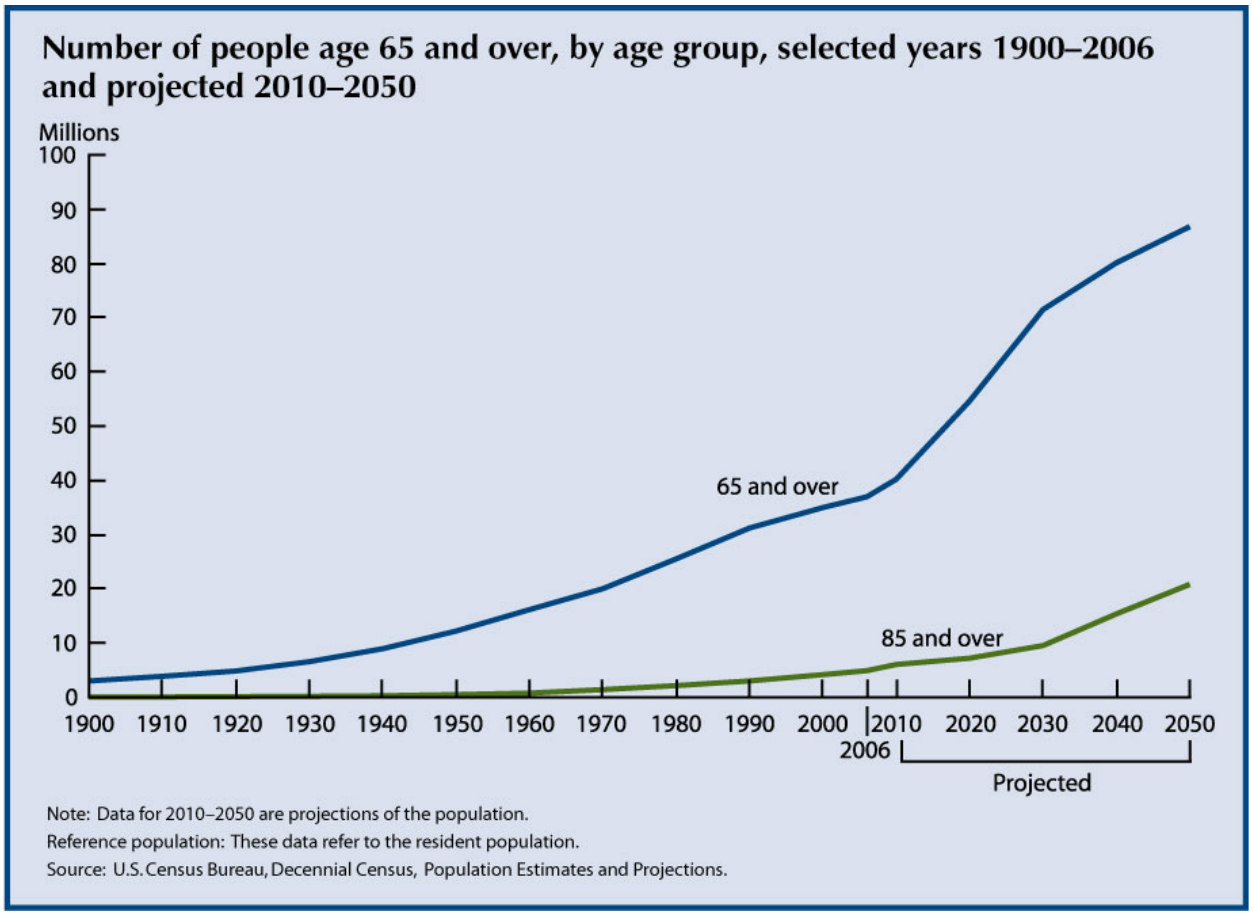

Exhibit 2: Table from Federal Interagency Forum on Aging-related Statistics. *Older Americans 2008: Numbers of Older Adults. Federal Interagency Forum on Aging-Related Statistics.*

TABLE 5. Projected Remaining Lifetime Use at Selected Ages in 2000

Age in 2000	Percentage in Nursing Homes	Remaining Risk of Use*	Expected Remaining Use in Years	Expected Years to Admission†	Nursing Home Users: Mean Remaining Use in Years	Nursing Home Users: Remaining Lifetime Use Distribution: Less than 3 Months	3 Months to 1 Year	1 Year to 5 Years	5 Years or Longer
	All Persons								
65	0.7	44	1.1	18.1	2.5	27	20	34	19
70	0.8	47	1.1	13.8	2.5	26	20	35	19
75	2.1	50	1.3	9.9	2.5	24	21	35	20
80	5.9	54	1.4	6.4	2.6	23	20	37	20
85	13.7	60	1.5	3.7	2.5	20	21	40	19
90	24.5	65	1.7	1.9	2.6	17	19	48	17
95	42.7	72	1.4	0.7	2.0	10	36	45	8
	Community Residents								
65	—	44	1.1	18.4	2.4	27	20	34	19
70	—	46	1.1	14.0	2.5	27	20	34	19
75	—	49	1.2	10.3	2.5	25	21	35	19
80	—	51	1.2	7.2	2.3	25	21	36	18
85	—	53	1.2	4.8	2.3	23	22	38	17
90	—	53	1.2	3.0	2.2	21	22	44	14
95	—	51	0.9	1.7	1.8	15	40	38	8

*Those already in a nursing home in the top panel have a 100 percent risk of entry.
†Those already in a nursing home in the top panel have a value of 0 for years until entry.

Exhibit 3: (Table 5) from Spillman & Lubitz (2002). Projecting Nursing Home use in 2000 & Beyond.

§483.15(a) Dignity

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Interpretive Guidelines: §483.15(a)

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

- *Encouraging and* assisting residents to dress in their own clothes appropriate to the time of day and individual preferences *rather than hospital-type gowns;*
- Labeling each resident's clothing in a way that respects his or her dignity (e.g., placing labeling on the inside of shoes and clothing);
- Promoting resident independence and dignity in dining such as avoidance of:
    - Day-to-day use of plastic cutlery and paper/plastic dishware;
    - Bibs *(also known as clothing protectors)* instead of napkins *(except by resident choice);*
    - *Staff standing over residents while assisting them to eat;*
    - *Staff interacting/conversing only with each other rather than with residents, while assisting residents;*
- Respecting residents *by* speaking respectfully, addressing the resident with a name of the resident's choice, *avoiding use of labels for residents such as "feeders,"* not excluding residents from conversations or discussing residents in community setting*s in which others can overhear private information*;

Exhibit 4: Excerpt of Revisions to Interpretive Guidelines Addressing 483.15 (a) Dignity: *Revisions in Red.* (CMS, 2009).

§483.15(b) Self-Determination and Participation

The resident has the right to—

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

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

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

Intent: §483.15(b)

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

Many types of choices are mentioned in this regulatory requirement. The first of these is choice over "activities." It is an important right for a resident to have choices to participate in preferred activities, whether they are part of the formal activities program or self-directed.

The second listed choice is "schedules." Residents have the right to have a choice over their schedules, consistent with their interests, assessments, and plans of care. Choice over "schedules" includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking, eating, bathing, and the time for going to bed at night. Residents have the right to choose health care schedules consistent with their interests and preferences, and the facility should gather this information in order to be proactive in assisting residents to fulfill their choices. For example, if a resident mentions that her therapy is scheduled at the time of her favorite television program, the facility should accommodate the resident to the extent that it can.

Exhibit 5: Excerpt of Revisions to Interpretive Guidelines Addressing 483.15(b) Resident Self-Determination and Participation: *Revisions in Red.* (CMS, 2009).

§483.15(e) Accommodation of Needs

The resident has the right to—

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

Interpretive Guidelines: §483.15(e)(1)

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

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

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

Exhibit 6a: Excerpt of Revisions to Interpretive Guidelines Addressing 483.15(e) Accommodation of Needs: *Revisions in Red.* (CMS, 2009).

§483.15(e) Accommodation of Needs, continued

The resident has the right to—

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

Interpretive Guidelines: §483.15(e)(1)

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

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

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

Staff should strive to reasonably accommodate the resident's needs and preferences as the resident makes use of the physical environment. This includes ensuring that items the resident needs to use are available and accessible to encourage confidence and independence (such as grooming supplies reachable near the bathroom sink), needed adaptive equipment (such as door handle grippers) are maintained in place and functional furniture is arranged to accommodate the resident's needs and preferences, etc. This does not apply to residents who need extensive staff assistance and are incapable of using these room adaptations.

Exhibit 6b: Excerpt of Revisions to Interpretive Guidelines Addressing 483.15(e) Accommodation of Needs, continued: *Revisions in Red.* (CMS, 2009).

§483.15(h) Environment

The facility must provide—

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

Interpretive Guidelines: §483.15(h)(1)

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

A "homelike environment" is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A personalized, homelike environment recognizes the individuality and the past and family members. *The intent of the word "homelike" in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. This concept of creating a home setting includes the elimination of institutional odors, and practices to the extent possible. Some good practices that serve to decrease the institutional character of the environment include the elimination of:*

- Overhead paging and piped-in music throughout the building;
- *Meal service in the dining room using trays (some residents may wish to eat certain meals in their rooms on trays);*
- *Institutional signage labeling work rooms/closets in areas visible to residents and the public;*
- *Medication carts (some innovative facilities store medications in locked areas in resident rooms);*
- *The widespread and long-term use of audible (to the resident) chair and bed alarms, instead of their limited use for selected residents for diagnostic purposes or according to their care planned needs. These devices can startle the resident and constrain the resident from normal repositioning movements, which can be problematic. For more information about the detriments of alarms in terms of their effects on residents and alternatives to the widespread use of alarms, see the 2007 CMS satellite broadcast training, "From Institutionalized to Individualized Care," Part 1, available through the National Technical Information Service and other sources such as the Pioneer Network;*
- *Mass purchased furniture, drapes, and bedspreads that all look alike throughout the building (some innovators invite the placement of some residents' furniture in common areas); and*
- *Large, centrally located nursing/care team stations.*

Exhibit 7: Excerpt of Revisions to Interpretive Guidelines Addressing 483.15(h) Environment: *Revisions in Red.* (CMS, 2009).