National Certification Council for Activity Professionals
Setting Standards of Excellence for Quality of Life through Education
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F-TAG 675 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.

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.