Activities Related F-Tag Guide

F-Tag #	Tag Title	CFR	Old F-Tag	Description
F-561	Resident Rights- Self Determination	483.10(f)(1)-3(8)	F-245	The resident has the right to choose activities consistent with his or her interests, assessments and plan of care.
F-565	Resident Rights-Resident/Family Group & Response	483.10(f)(5)(i)-(v)(6)(7)	F-243, F-244	The resident has a right to organize and participate in resident & family groups.
F-679	Quality of Life-Activities Meet Interests/Needs of Each Resident	483.24(c)(1)	F-248	The facility must provide based on comprehensive assessments, 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.
F-680	Quality of Life- Qualifications of Activity Professional	483.24(c)(2)(i)(ii)(A)-(D)	F-249	The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered by the State, eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized by an accrediting body; or has 2 years of experience in a social or recreational program within the last 5 years; or a qualified occupational therapist or occupational therapist assistant; or has completed a training course approved by the State.
F-920	Physical Environment- Requirements for Activity Rooms	483.90(h)(1)-(4)	F-464	The facility must provide one or more rooms designated for resident activities. It is to be well lighted, well ventilated, adequately furnished and have sufficient space to accommodate all activities.

Other Potentially Related F-Tags That Could Be Cited For Activities

F-Tag #	Tag Title	CFR	Old F-Tag	Description
F-563	Residents Rights- Right to Receive/Deny Visitors	483.10(f)(4)(ii)-(v)	F-172	The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.
MDS Related Potential F-Tags				
F-636	Resident Assessments- Comprehensive Assessments & Timing	483.20(b)(1)(2)(i)(iii)	F-272	A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences including activity pursuit, using the resident assessment instrument (RAI) specified by CMS.

F-637	Resident Assessments- Comprehensive Assessment after Significant Change	483.20(b)(2)(ii)	F-274	Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
F-641	Resident Assessments- Accuracy of Assessments	483.20(g)	F-278	The assessment must accurately reflect the resident's status. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments.
Care Plan Related Potential F-Tags				
F-655	Comprehensive Resident Centered Care Plans- Baseline Care Plan	483.21(a)(1)-(3)	N/A	The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must (i) Be developed within 48 hours of a resident's admission and (ii) Include the minimum healthcare information necessary to properly care for a resident. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

F-657	Comprehensive Resident Centered Care Plans- Care Plan Timing and Revision	483.21(b)(2)(i)-(iii)	F-280	A comprehensive care plan must be (i) developed within 7 days after completion of the comprehensive assessment, (ii) Prepared by an interdisciplinary team, reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan with input from the resident or resident's representative to meet the resident's needs?
F-658	Comprehensive Resident Centered Care Plans- Services provided Meet Professional Standards	483.21(b)(3)(i)	F-281	The services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency.
Other Miscellaneous Potential F-Tags				
F-838	Administration- Facility Assessment	483.70(e)(1)-(3)	N/A	The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Furthermore, the assessment must include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. This also includes any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspects of care identified.

F-842	Resident Assessments & Administration- Resident Records-Identifiable Information	483.20(f)(5)& 483.70(i)(1)-(5)	F-164 F-514 F-515 F-516	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized. The medical record shall reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. Staff must document a resident's medical and nonmedical status when any positive or negative condition change occurs, at a periodic reassessment and during the annual comprehensive assessment. The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team.

REFERENCE

1. Centers of Medicare & Medicaid Services, Department of Health and Human Services; Appendix PP: Guidance to Surveyors for LTC Facilities (November 2017 Revisions). State Operations Manual(SOM) 42.C.F.R. 483.
2. Centers of Medicare & Medicaid Services, Department of Health and Human Services; Activities Critical Element Pathway (Form CMS 20065) 5/17 revision.