in an early palliative phase. Data and method: Data consisted of interviews with 20 representatives of care organizations and participant observations at two nursing homes. Qualitative content analysis was used to code transcribed interviews and observation notes. Results: Our observations suggested that it was challenging to realize lifestyle activities. Activities had to be initiated by staff and ideas about community based on interest among residents seemed unrealistic. Residents had not chosen the nursing homes based on thematic interest, and some were not aware that a profile existed. Still, representatives described lifestyle profiles as a means of personalizing care in relation to established lifestyles of residents, and making facilities stand out as unique and attractive. This motive was closely linked to perceptions of an increased marketization of Swedish eldercare. Discussion: Results are discussed in relation to risks that nursing homes achieve popularity by marketing lifestyles that appeal to ideas among the public and adult children of residents rather than to residents themselves. This may lead to denial of the extreme frailty of residents and the everyday reality of nursing home care.

PERCEPTIONS OF QUALITY OF LIFE AND AGREEMENT AMONG STAKEHOLDERS IN MIDWEST NURSING HOMES
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Quality of life has been uniquely defined by different stakeholders. Accurately defining and identifying quality of life for nursing home (NH) residents has been an obstacle, however. Nursing homes can influence resident quality of life by adjusting policies, practices, and environments (Kane, 2003). Prior research has indicated that perceptions of quality of life by residents and certified nursing assistants (CNAs) have also differed (Kane et al., 2005). This study analyzed levels of agreement in quality of life ratings among five stakeholders (i.e., residents, CNAs, activity directors, social workers, administrators) within 47 NHs. Structured interviews were conducted with long-stay residents, CNAs, an activity director, a social worker, and the administrator. Data collected included interviewees’ perceptions of quality of life, along with ratings using a five-point Likert scale, to evaluate both quality of life and quality of NH practices (e.g., food quality and variety, activities, staff responsiveness). Qualitative questions assessed how each stakeholder defined and what contributed to “good” quality of life. Level of agreement between perceived quality of life from stakeholders and quality ratings were evaluated and common themes in stakeholders’ qualitative responses were identified. Relationships between interviewees’ perceptions and ratings and facilities’ ratings of quality (i.e., Centers for Medicare and Medicaid Services (CMS) 5-Star ratings, Artifacts of Culture Change scores from CMS) were also examined. With more understanding of resident-defined quality of life and the implications of agreement on NH quality, leadership and staff will have opportunities to better understand how to improve the quality of life for NH residents.

PERSON-CENTERED CARE IS ALL ABOUT THE PEOPLE
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Despite the importance of person-centered care in long-term services and supports, little is known about what type of organizations are most likely to provide it, or the quality measures that are associated with implementing person-centered practices. This study provides a look at nursing home characteristics associated with providing more person-centered care, as well as the characteristics that don’t significantly differ among facilities with very different levels of person-centered practices. In 2016 the Ohio Dept. of Aging launched a project to improve nursing home resident and staff relationships and person-centered care (PCC) practices. Facilities were recruited by regional long-term care ombudsmen and about 10 facilities from each region participated in a no-cost intervention to improve PCC (n=124). At baseline, ombudsmen collected data from staff in each facility using the Person-Centered Care Index (PCCI), facilities reported the extent to which they were using the Preferences for Everyday Living Inventory (PELI), and facility information regarding deficiencies, staffing and star ratings was extracted from Nursing Home Compare. Scores on the PCCI ranged from 1.63 to 2.56 in a possible range from 1 to 4, with 1 being most person-centered. Results show that staffing variables (i.e. hours per resident day) are the facility characteristic most significantly and highly related to the provision of person-centered care. Other factors such as ownership, extent of PELI implementation, and survey deficiencies were not significantly related to PCC. Implications for nursing home quality improvement and provision of person-centered nursing home care will be discussed.

PERSPECTIVES OF NURSING HOME RESIDENTS AND STAFF ON BARRIERS AND FACILITATORS TO ACTIVITY ENGAGEMENT
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Engaging in meaningful activities has been shown to improve nursing home residents’ quality of life as well as physical and mental health. However, nursing home residents are often found to be inactive and lacking meaningful engagement. Thus, in order to promote optimal engagement, it is vital to first understand the current practice of how residents are engaged in meaningful activities. As an initial step towards examining this topic, this study examined barriers and facilitators to engaging residents. A qualitative study was conducted in three purposively selected nursing homes (e.g., geographic location, staffing hours), which included one-on-one interviews, field notes, and facility observations. Nursing home staff (n=12) and resident (n=15) interviews elicited perspectives on activity engagement within the facility. Fourteen days of observations, spanning 4–5 hours, were completed in each facility to understand the daily routines of the staff and residents. A grounded theory approach was used to analyze the transcripts for major themes and sub-themes. Finally, triangulation of data sources was used to confirm themes that arose. Commonly identified barriers to engagement by staff members included time constraints and the cognitive status of residents. Barriers identified by the residents included limited opportunities to participate in activities. Facilitators that were identified by both staff and residents included the culture of the facility, promoting one-on-one patient-staff interactions, and integrating family