F677
(Rev.)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and

DEFINITIONS
"**Oral care"** refers to the maintenance of a healthy mouth, which includes not only teeth, but the lips, gums, and supporting tissues. This involves not only activities such as brushing of teeth or oral appliances, but also maintenance of oral mucosa.

"Speech, language or other functional communication systems" refers to the resident's ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture, behavior, or a combination of these (e.g., a communication board or electronic augmentative communication device).

"Assistance with the bathroom" refers to the resident's ability to use the toilet room (or commode, bedpan, urinal); transfer on/off the toilet, clean themselves, change absorbent pads or briefs, manage ostomy or catheter, and adjust clothes.

"Transfer" refers to resident's ability to move between surfaces - to/from: bed, chair, wheelchair, and standing positions. (Excludes to/from bath/toilet.)

GUIDANCE
The existence of a clinical diagnosis shall not justify a decline in a resident's ability to perform ADLs unless the resident's clinical picture reflects the normal progression of the disease/ condition has resulted in an unavoidable decline in the resident's ability to perform ADLs. Conditions which may demonstrate an unavoidable decline in the resident's ability to perform ADLs include but are not limited to the following:

- The natural progression of a debilitating disease with known functional decline;
- The onset of an acute episode causing physical or mental disability while the resident is receiving care to restore or maintain functional abilities; and
- The resident's or his/her representative's decision to refuse care and treatment to restore or maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment; counsel and/or offer alternatives to the resident or representative. The decision to refuse care and treatment must be documented in the clinical record. Documentation must include interventions identified on the care plan and in place to minimize or decrease functional loss that were refused by the resident or resident's representative and any interventions that were substituted with consent of the resident and/or representative to minimize further decline. **NOTE**: In some cases, residents with dementia may resist the manner in which care is being provided, or attempted, which can be misinterpreted as declination of care. In some cases the resident with dementia does not understand what is happening, or may be fearful of unfamiliar staff, or may be anxious or frustrated due to inability to communicate. Facility staff are responsible to attempt to identify the underlying cause of the "refusal/declination" of care.

- Note also that depression is a potential cause of excess disability and, where appropriate, therapeutic interventions should be initiated. Follow up if the resident shows signs/symptoms of depression even if not indicated on his or her MDS.

If it is determined that the resident's inability to perform ADLs occurred after admission due to an unavoidable decline, such as the progression of the resident's disease process, surveyors must still determine that interventions to assist the resident are identified and implemented immediately.

Appropriate treatment and services includes all care provided to residents by staff, contractors, or volunteers of the facility to maximize the resident's functional abilities. This includes pain relief and control, especially when it is causing a decline or a decrease in the quality of life of the resident.

NOTE: For evaluating a resident's ADLs and determining whether a resident's abilities have declined, improved, or stayed the same within the last twelve months, the following definitions as specified in the State's Resident Assessment Instrument (RAI) Manual are used in reference to the Assessment Reference Date (ARD):

- *Independent: if the resident completes the activity by themself with no assistance from a helper.*
- *Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).*
- *Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.*
- *Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
- *Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*
- *Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.*

PROCEDURES

Use the Activities of Daily Living Critical Element (CE) Pathway, along with the above interpretive guidelines when determining if facility practices are in place to identify, evaluate, and intervene to, maintain, improve, or prevent an avoidable decline in ADLs. In addition, use this pathway for the resident who is unable to perform ADLs. Briefly review the most recent comprehensive assessment, care plan, physician orders, as well as ADL documentation/flow sheets on various shifts, to identify whether the facility has:

- Recognized and assessed an inability to perform ADLs, or a risk for decline in any ability they have to perform ADLs;
- Developed and implemented interventions in accordance with the resident's assessed needs, goals for care, preferences, and recognized standards of practice that address the identified limitations in ability to perform ADLs;
- Monitored and evaluated the resident's response to care plan interventions and

treatment; and

- Revised the approaches as appropriate.

NOTE: For concerns related to facility failure to provide care, services, equipment or assistance to a resident with limited mobility, refer to F688, Mobility.