SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior function, admission *and discharge* performance, discharge goals, *performance throughout a resident's stay, mobility device use, and range of motion*. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:
3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

↓ Enter Codes in Boxes	
☐	**A. Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	**B. Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**D. Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Item Rationale

- Knowledge of the resident's functioning prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or *their* family about, or review the resident's medical records describing, the resident's prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent:** if the resident completed the activities by *them*self, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help:** if the resident needed partial assistance from another person to complete the activities.
- **Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
- **Code 8, Unknown:** if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable:** if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

Draft

GG0100: Prior Functioning: Everyday Activities (cont.)

Coding Tips

- Record the resident's usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the resident's ability is available after attempts to interview the resident or *their* family and after reviewing the resident's medical record, code as 8, Unknown.
- *Completing the stair activity for GG0100C indicates that a resident went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift) and/or with or without some level of assistance.*
- *Going up and down a ramp is not considered going up and down stairs for coding GG0100C.*

Examples for Coding Prior Functioning: Everyday Activities

1. **Self-Care:** *Resident* T was admitted to an acute care facility after sustaining a stroke and subsequently admitted to the SNF for rehabilitation. Prior to the stroke, *Resident* T was independent in eating and using the toilet; however, *Resident* T required assistance for bathing and putting on and taking off *their* shoes and socks. The assistance needed was due to severe arthritic lumbar pain upon bending, which limited *their* ability to access *their* feet.

   Coding: GG0100A would be coded 2, Needed Some Help.
   Rationale: *Resident* T needed partial assistance from a helper to complete the activities of bathing and dressing. While *Resident* T did not need help for all self-care activities, *they* did need some help. Code 2 is used to indicate that *Resident* T needed some help for self-care.

2. **Self-Care:** *Resident* R was diagnosed with a progressive neurologic condition five years ago. *They* live in a long-term nursing facility and *were* recently hospitalized for surgery and *have* now been admitted to the SNF for skilled services. According to *Resident* R's *spouse*, prior to the surgery, *Resident* R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

   Coding: GG0100A would be coded 1, Dependent.
   Rationale: *Resident* R's *spouse* has reported that *Resident* R was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. Code 1, Dependent, is appropriate based upon this information.

3. **Indoor Mobility (Ambulation):** Approximately three months ago, *Resident* K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. *Resident* K has been living at home with *their spouse* and developed aspiration pneumonia. After this most recent hospitalization, *they were* admitted to the SNF for a diagnosis of aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, *Resident* K needed some assistance when walking.

Draft

GG0100: Prior Functioning: Everyday Activities (cont.)

Coding: GG0100B would be coded 2, Needed Some Help.

Rationale: While the resident experienced a cardiac event three months ago, *they* recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The resident's prior functioning is based on the time immediately before *their* most recent condition exacerbation that required acute care.

4. **Indoor Mobility (Ambulation):** *Resident* L had a stroke one year ago that resulted in *their* using a wheelchair to self-mobilize, as *they were* unable to walk. *Resident* L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

   Coding: GG0100B would be coded 9, Not Applicable.

   Rationale: The resident did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).

5. **Stairs:** Prior to admission to the hospital for bilateral knee surgery, followed by *their* recent admission to the SNF for rehabilitation, *Resident* V experienced severe knee pain upon ascending and particularly descending *their* internal and external stairs at home. *Resident* V required assistance from *their spouse* when using the stairs to steady *them* in the event *their* left knee would buckle. *Resident* V's *spouse* was interviewed about *their spouse*'s functioning prior to admission, and the therapist noted *Resident* V's prior functional level information in *their* medical record.

   Coding: GG0100C would be coded 2, Needed Some Help.

   Rationale: Prior to admission, *Resident* V required some help in order to manage internal and external stairs.

6. **Stairs:** *Resident* P has expressive aphasia and difficulty communicating. SNF staff have not received any response to their phone messages to *Resident* P's family members requesting a return call. *Resident* P has not received any visitors since *their* admission. The medical record from *their* prior facility does not indicate *Resident* P's prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.

   Coding: GG0100C would be coded 8, Unknown.

   Rationale: Attempts were made to seek information regarding *Resident* P's prior functioning; however, no information was available.

7. **Functional Cognition:** *Resident* K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. *Resident* K has been admitted to the SNF for rehabilitation. *Resident* K's caregiver reports that when living at home, *Resident* K needed reminders to take *their* medications on time, manage *their* money, and plan tasks, especially when *they were* fatigued.

   Coding: GG0100D would be coded 2, Needed Some Help.

   Rationale: *Resident* K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.

Draft

GG0100: Prior Functioning: Everyday Activities (cont.)

8. **Functional Cognition:** *Resident* R had a stroke, resulting in a severe communication disorder. *Their* family members have not returned phone calls requesting information about *Resident* R's prior functional status, and *their* medical records do not include information about *their* functional cognition prior to the stroke.

   Coding: GG0100D would be coded 8, Unknown.

   Rationale: Attempts to seek information regarding *Resident* R's prior functioning were made; however, no information was available.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury Complete only if A0310B = 01	
↓	**Check all that apply**
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

Item Rationale

- Knowledge of the resident's routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or *their* family or review the resident's medical records to determine the resident's use of prior devices and aids.

Coding Instructions

- Check all devices that apply.
- **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

- For GG0110D, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).
- GG0110C, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body-style lifts.

Draft

GG0110: Prior Device Use (cont.)

Example for Coding Prior Device Use

1. *Resident* M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. *They are* unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. *They* use a motorized wheelchair to mobilize.

   Coding: GG0110B would be checked.
   Rationale: *Resident* M used a motorized wheelchair prior to the current illness/injury.

GG0115: Functional Limitation in Range of Motion

GG0115. Functional Limitation in Range of Motion		
Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days		
Coding: 0. **No impairment** 1. **Impairment on one side** 2. **Impairment on both sides**	↓ **Enter Codes in Boxes**	
	☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
	☐	**B. Lower extremity** (hip, knee, ankle, foot)

Intent: *The intent of GG0115 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places them at risk of injury. When completing this item, staff members should refer to items in GG0130 and GG0170 and view the limitation in ROM, taking into account activities the resident is able to perform.*

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION
Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

Item Rationale

Health-related Quality of Life

- *Functional impairment could place the resident at risk of injury or interfere with performance of activities of daily living.*

Planning for Care

- *Individualized care plans should address possible reversible causes such as deconditioning and adverse side effects of medications or other treatments.*

Draft

GG0115: Functional Limitation in Range of Motion (cont.)

Steps for Assessment

1. *Review the medical record for references to functional range-of-motion limitation during the 7-day observation period.*
2. *Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM.*
3. *Coding for functional ROM limitations is a three-step process:*
   - *Test the resident's upper and lower extremity ROM (See item 6 below for examples).*
   - *If the resident is noted to have limitation of upper- and/or lower-extremity ROM, review GG0130 and GG0170 and/or directly observe the resident to determine whether the limitation interferes with function or places the resident at risk for injury.*
   - *Code GG0115A and GG0115B as appropriate based on the above assessment.*
4. *Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).*
5. *Staff member observations of various activities, including ADLs, may be used to determine whether any ROM limitations have an impact on the resident's functional abilities.*
6. *Although this item codes for the presence or absence of functional limitation related to ROM, thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:*
   - *Ask the resident to follow your verbal instructions for each movement.*
   - *Demonstrate each movement (e.g., ask the resident to do what you are doing).*
   - *Actively assist the resident with the movements by supporting their extremity and guiding it through the joint ROM.*

   Lower Extremity—*includes hip, knee, ankle, and foot*

   While resident is lying supine in a flat bed, instruct the resident to flex (pull toes up toward head) and extend (push toes down away from head) each foot. Then ask the resident to lift their leg one at a time, bending it at the knee to a right angle (90 degrees). Then ask the resident to slowly lower their leg and extend it flat on the mattress. If assessing lower-extremity ROM by observing the resident, the flexion and extension of the foot mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower-body clothing.

Draft

GG0115: Functional Limitation in Range of Motion (cont.)

***Upper Extremity**—includes shoulder, elbow, wrist, and fingers*

For each hand, instruct the resident to make a fist and then open the hand. With resident seated in a chair, instruct them to reach with both hands and touch palms to back of head. Then ask resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper-extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair.

Coding Tips

- *Do not look at limited ROM in isolation. You must determine whether the limited ROM has an impact on functional ability or places the resident at risk for injury. For example, if the resident has an amputation, it does not automatically mean that they are limited in function. A resident with an amputation may not have a particular joint in which a certain range of motion can be tested, however, that does not mean that the resident necessarily has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If a resident with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.*

Coding Instructions for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)

- ***Code 0, no impairment:*** *if resident has full functional range of motion on the right and left side of upper/lower extremities.*
- ***Code 1, impairment on one side:*** *if resident has an upper- and/or lower-extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury.*
- ***Code 2, impairment on both sides:*** *if resident has an upper- and/or lower-extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury.*

Draft

GG0115: Functional Limitation in Range of Motion (cont.)

Examples for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)

1. *The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. They are able to perform grooming activities (e.g., brush their teeth, comb their hair) with their right upper extremity and are also able to pivot to their wheelchair with the assistance of one person. They are, however, unable to voluntarily move their left side (limited arm, hand, and leg motion), as they have a flaccid left hemiparesis from a prior stroke.*

   Coding: *GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 1, lower-extremity impairment on one side.*
   Rationale: *Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows the resident to be as independent as possible.*

2. *The resident had shoulder surgery and can't brush their hair with their right arm or raise their right arm above their head. The resident can brush their hair with their left arm and has no impairment on the lower extremities.*

   Coding: *GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 0, no impairment.*
   Rationale: *Impairment due to shoulder surgery affects only one side of their upper extremities.*

3. *The resident has a diagnosis of Parkinson's and ambulates with a shuffling gait. The resident has had three falls in the past quarter and often forgets their walker, which they need to ambulate. They have tremors of both upper extremities that make it very difficult for them to feed themself, brush their teeth, or write.*

   Coding: *GG0115A would be coded 2, upper-extremity impairment on both sides. GG0115B would be coded 2, lower-extremity impairment on both sides.*
   Rationale: *Impairment due to Parkinson's disease affects the resident's upper and lower extremities on both sides.*

Draft

GG0120: Mobility Devices

GG0120. Mobility Devices	
↓ Check all that were normally used in the last 7 days	
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

Item Rationale

Health-related Quality of Life

- *Maintaining independence is important to an individual's feelings of autonomy and self-worth. The use of devices may assist the resident in maintaining that independence.*

Planning for Care

- *A resident's ability to move about their room, unit or nursing home may be directly related to the use of devices. It is critical that staff members assure that the resident's independence is optimized by making mobility devices available on a daily basis, if needed.*

Steps for Assessment

1. *Review the medical record for references to locomotion during the 7-day observation period.*
2. *Talk with staff members who work with the resident as well as family/significant others about devices the resident used for mobility during the observation period.*
3. *Observe the resident during locomotion.*

Coding Instructions

Record the type(s) of mobility devices the resident normally uses for locomotion (in room and in facility). Check all that apply:

- ***Check GG0120A, Cane/crutch:*** *if the resident used a cane or crutch, including single-prong, tripod, quad cane, etc.*
- ***Check GG0120B, Walker:*** *if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with or without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.*
- ***Check GG0120C, Wheelchair (manual or electric):*** *if the resident normally sits in a wheelchair when moving about. Include wheelchairs that are hand propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.*
- ***Check GG0120D, Limb prosthesis:*** *if the resident used an artificial limb to replace a missing extremity.*

Draft

GG0120: Mobility Devices (cont.)

- ***Check GG0120Z, None of the above:*** *if the resident used none of the mobility devices listed in GG0120 or locomotion did not occur during the observation period.*

Examples

1. *The resident uses a quad cane daily to walk in the room and on the unit. The resident uses a standard push wheelchair that they self-propel when leaving the unit because of their issues with endurance.*

   Coding: *GG0120A, Cane/crutch, and GG0120C, Wheelchair, would be checked.*
   Rationale: *The resident uses a quad cane in their room and on the unit and a wheelchair off the unit.*

2. *The resident has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied, the resident is able to ambulate independently.*

   Coding: *GG0120D, Limb prosthesis, would be checked.*
   Rationale: *The resident uses a leg prosthesis for ambulating.*

Draft

GG0130: Self-Care (3-day assessment period) Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐		**I. Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Draft

GG0130: Self-Care (3-day assessment period) Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	**I. Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Draft

GG0130: Self-Care (OBRA/Interim)

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)
Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	**I. Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Draft

GG0130: Self-Care (cont.)

Item Rationale

Health-related Quality of Life

- Residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the *facility*.
- *Most nursing home residents need some physical assistance and are at risk of further physical decline. The amount of assistance needed and the risk of decline vary from resident to resident.*
- *A wide range of physical, neurological, and psychological conditions and cognitive factors can adversely affect physical function.*
- *Dependence on others for ADL assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny.*
- *As inactivity increases, complications such as pressure ulcers, falls, contractures, depression, and muscle wasting may occur.*

DEFINITION

ADL
Tasks related to personal care, such as any of the tasks listed in GG0130 and GG0170.

Planning for Care

- *Individualized care plans should address strengths and weaknesses, possible reversible causes such as deconditioning, and adverse side effects of medications or other treatments. These may contribute to loss of self-sufficiency. In addition, some neurologic injuries such as stroke may continue to improve for months after an acute event.*
- *For some residents, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.*
- *Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident.*
- *Many residents may require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or given adequate time to complete a task while being provided with graduated prompting and assistance. This type of supervision requires skill, time, and patience.*
- *Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.*
- *Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.*

Draft

GG0130: Self-Care (cont.)

Steps for Assessment

1. Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.
   - For *residents in a Medicare Part A stay,* the admission assessment period is the first *3* days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. *The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.*
     - ***Note:*** *If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B and both columns are required. In these scenarios, do not complete Column 5. OBRA/Interim Performance.*
   - For *residents in a Medicare Part A stay, the assessment period for* the Interim Payment Assessment (A0310B = 08) is the last 3 days (i.e., the ARD *plus 2 previous calendar* days).
   - *For residents in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus 2 previous calendar days. For all other Discharge assessments, the assessment period is A2000, Discharge Date plus 2 previous calendar days.*
   - *When completing an OBRA-required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.*
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

DEFINITIONS

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

QUALIFIED CLINICIAN
Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

PRIOR TO THE BENEFIT OF SERVICES *means prior to provision of any care by facility staff that would result in more independent coding.*

Draft

GG0130: Self-Care (cont.)

3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. *For residents in a Medicare Part A stay, t*he admission functional assessment, when possible, should be conducted prior to the *benefit of services* in order to reflect the resident's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

Coding Instructions

- When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by *them*self with no assistance from a helper.
- **Code 05, 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).
- **Code 04, 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. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
    - *Code 04, Supervision or touching assistance: if the resident requires only verbal cueing to complete the activity safely.*
- **Code 03, 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.
- **Code 02, 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.

Draft

GG0130: Self-Care (cont.)

- **Code 01, 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.
    - *Code 01, Dependent: if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance.*
    - *Code 01, Dependent: if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed).*
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.

Draft

GG0130: Self-Care (cont.)

Decision Tree

Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.

Draft

GG0130: Self-Care (cont.)

Assessment Period

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay. *Additionally, an OBRA Admission assessment (A0310A = 1) is required for a new resident and, under some circumstances, a returning resident and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA Admission assessment.*
  - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
  - *For an OBRA Admission assessment, code the resident's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.*
- ***OBRA/*Interim:** The Interim Payment Assessment (IPA) *(A0310B = 08)* is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. *OBRA assessments (A0310A = 01 – 06) are required for residents in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual.*
  - For Section GG on the IPA *or an OBRA assessment*, providers will use the same 6-point scale and activity not attempted codes to *assess the resident's usual functional performance during the 3-day assessment period*.
  - The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD *plus* 2 *previous* calendar days). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
  - *For Section GG on OBRA assessments other than the Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days).*

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GG0130: Self-Care (cont.)

- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000). *An OBRA Discharge assessment is required when the resident is discharged from the facility.* Please see Chapter 2 and Section A of the RAI Manual for additional details regarding Discharge assessments.
  - For the *PPS* Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last *3* calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A *plus 2 previous calendar* days prior to the day of discharge from Medicare Part A.
  - *On standalone OBRA Discharge assessments (i.e., A0310F = 10 or 11 AND A0310H = 0), code the resident's usual performance during last 3 days of their stay (i.e., A2000, Discharge Date plus 2 previous calendar days).*

Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).
- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the resident refused to attempt the activity; code as 09 if the activity is not applicable for the resident (the activity did not occur at the time of the assessment and prior to the current illness, injury, or exacerbation); code as 10 if the resident was not able to attempt the activity due to environmental limitations; or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.

GG0130: Self-Care (cont.)

- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.
- *CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.*
- *Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).*

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, not the resident's most independent performance and not the resident's most dependent performance. A provider may need to use the entire assessment period to obtain the resident's usual performance.

GG0130: Self-Care (cont.)

Coding Tips for GG0130A, Eating

- *The intent of GG0130A, Eating is to assess the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.*
- The administration of tube feedings and parenteral nutrition is not considered when coding this activity.
- The following is guidance for some situations in which a resident receives tube feedings or parenteral nutrition:
  - If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns.
  - If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth **prior to the current** illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
  - If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code Eating based on the amount of assistance the resident requires to eat and drink by mouth.
  - *Assistance with tube feedings or parenteral nutrition is not considered when coding the item Eating.*
- *If a resident requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing.*
- *If a resident swallows safely without assistance, exclude swallowing from consideration when coding GG0130A, Eating.*
- If the resident eats finger foods using *their* hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with *their* hands independently, for example, the resident would be coded as 06, Independent.
- *For a resident taking only fluids by mouth, the item may be coded based on ability to bring liquid to the mouth and swallow liquid, once the drink is placed in front of the resident.*

Examples for Coding Performance

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

GG0130: Self-Care (cont.)

Examples for GG0130A, Eating

1. **Eating:** *Resident* S has multiple sclerosis, affecting *their* endurance and strength. *Resident* S prefers to feed *them*self as much as *they are* capable. During all meals, after eating three-fourths of the meal by *them*self, *Resident* S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed *them* the remainder of the meal.

   Coding: GG0130A would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

2. **Eating:** *Resident* M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto *Resident* M's hand that supports the eating utensil within *their* hand. At the start of each meal *Resident* M can bring food and liquids to *their* mouth. *Resident* M then tires and the certified nursing assistant feeds *them* more than half of each meal.

   Coding: GG0130A would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

3. **Eating:** The dietary aide opens all of *Resident* S's cartons and containers on *their* food tray before leaving the room. There are no safety concerns regarding *Resident* S's ability to eat. *Resident* S eats the food *them*self, bringing the food to *their* mouth using appropriate utensils and swallowing the food safely.

   Coding: GG0130A would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

4. **Eating:** *Resident* H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears *their* throat due to difficulty with pharyngeal peristalsis. *They* require verbal cues from the certified nursing assistant to use the compensatory strategy of extra swallows to clear the food.

   Coding: GG0130A would be coded 04, Supervision or touching assistance.
   Rationale: *Resident* H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

5. **Eating:** *Resident* R is unable to eat by mouth since *they* had a stroke one week ago. *They* receive nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

   Coding: GG0130A would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not eat or drink by mouth at this time due to *their* recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to *their* recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

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GG0130: Self-Care (cont.)

Coding Tips for GG0130B, Oral hygiene

- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.
- *For a resident who is edentulous, code Oral hygiene based on the type and amount of assistance required from a helper to clean the resident's gums.*

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to *Resident* S as *they* walk to the bathroom. The nurse applies toothpaste onto *Resident* S's toothbrush. *Resident* S then brushes *their* teeth at the sink in the bathroom without physical assistance or supervision. Once *Resident* S is done brushing *their* teeth and washing *their* hands and face, the nurse returns and provides steadying assistance as the resident walks back to *their* bed.

   Coding: GG0130B would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before *Resident* S brushes *their* teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*

2. **Oral hygiene:** At night, the certified nursing assistant provides *Resident* K water and toothpaste to clean *their* dentures. *Resident* K cleans *their* upper denture plate. *Resident* K then cleans half of *their* lower denture plate, but states *they are* tired and unable to finish cleaning *their* lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and *Resident* K replaces the dentures in *their* mouth.

   Coding: GG0130B would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

3. **Oral hygiene:** *Resident* W is edentulous (without teeth) and *their* dentures no longer fit *their* gums. In the morning and evening, *Resident* W begins to brush *their* upper gums after the helper applies toothpaste onto *their* toothbrush. *Resident W* brushes *their* upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing *their* back upper gums and *their* lower gums.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The resident begins the activity. The helper completes the activity by performing more than half the effort.

4. **Oral hygiene:** *Resident* D has experienced a stroke. *They* can brush *their* teeth while sitting on the side of the bed, but when the certified nursing assistant hands *them* the toothbrush and toothpaste, *they* look up at *them* puzzled what to do next. The certified nursing assistant cues *Resident* D to put the toothpaste on the toothbrush and instructs *them* to brush *their* teeth. *Resident* D then completes the task of brushing *their* teeth.

   Coding: GG0130B would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing *their* teeth.

Draft

GG0130: Self-Care (cont.)

Coding Tips for GG0130C, Toileting hygiene

- Toileting hygiene *(managing clothing and perineal cleansing) takes place* before and after *use of the toilet, commode, bedpan, or urinal.* If the resident *completes a bowel toileting program in bed, code the item Toileting hygiene based on the resident's need for assistance managing clothing and perineal cleansing.*
- *Includes:*
  - *Performing perineal hygiene.*
  - *Managing clothing (including undergarments and incontinence products, such as incontinence briefs or pads) before and after voiding or having a bowel movement.*
  - *Adjusting clothing relevant to the individual resident.*
- If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident before and after moving *their* bowels.
- *When the resident requires different levels of assistance to perform toileting hygiene after voiding versus after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity.*
- *If a resident manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.*
- *If a resident has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.*
  - *For example, if the resident has an indwelling urinary catheter and has bowel movements, code Toileting hygiene based on the type and amount of assistance needed by the resident before and after moving their bowels. This may include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.*

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** *Resident* J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as *Resident* J pulls down *their* pants and underwear before sitting down on the commode. When *Resident* J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as *Resident* J wipes *their* perineal area and pulls up *their* pants and underwear without assistance.

   Coding: GG0130C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

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GG0130: Self-Care (cont.)

2. **Toileting hygiene:** *Resident* J is morbidly obese and has a diagnosis of debility. *They* request the use of a bedpan when voiding or having bowel movements and require two certified nursing assistants to pull down *their* pants and underwear and mobilize *them* onto and off the bedpan. *Resident* J is unable to complete any of *their* perineal/perianal hygiene. Both certified nursing assistants help *Resident* J pull up *their* underwear and pants.

   Coding: GG0130C would be coded 01, Dependent.

   Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

3. **Toileting hygiene:** *Resident* C has Parkinson's disease and significant tremors that cause intermittent difficulty for *them* to perform perineal hygiene after having a bowel movement in the toilet. *They* walk to the bathroom with close supervision and lower *their* pants, but ask the certified nursing assistant to help *them* with perineal hygiene after moving *their* bowels. *They* then pull up *their* pants without assistance.

   Coding: GG0130C would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by *them*self. Walking to the bathroom is not considered when scoring toileting hygiene.

4. **Toileting hygiene:** *Resident* Q has a progressive neurological disease that affects *their* fine and gross motor coordination, balance, and activity tolerance. *They* wear a hospital gown and underwear during the day. *Resident* Q uses a bedside commode as *they* stead*y them*self in standing with one hand and initiates pulling down *their* underwear with the other hand but need assistance to complete this activity due to *their* coordination impairment. After voiding, *Resident* Q wipes *their* perineal area without assistance while sitting on the commode. When *Resident* Q has a bowel movement, a certified nursing assistant performs perineal hygiene as *Resident* Q needs to steady *them*self with both hands to stand for this activity. *Resident* Q is usually too fatigued at this point and requires full assistance to pull up *their* underwear.

   Coding: GG0130C would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half the effort needed for the resident to complete the activity of toileting hygiene.

Coding Tips for GG0130E, Shower/bathe self

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident's back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.
- Assessment of Shower/bathe self can take place in *any location including* a shower or bath or at a sink *or in bed* (i.e., full body sponge bath). *Bathing can be assessed with the resident seated on a tub bench.*
- *Code 05, Setup or clean-up assistance, if the resident can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks.*

GG0130: Self-Care (cont.)

- *Code 05, Setup or clean-up assistance, if the only help the resident requires is assistance before the bathing activity to cover wounds or devices for water protection during bathing.*
- If the resident cannot bathe *their* entire body because of a medical condition *(e.g., a cast or a nonremovable dressing)*, then code Shower/bathe self based on the amount of assistance needed to complete the activity.

Examples for GG0130E, Shower/bathe self

1. **Shower/bathe self:** *Resident* J sits on a tub bench as *they* wash, rinse, and dry *them*self. A certified nursing assistant stays with *them* to ensure *their* safety, as *Resident* J has had instances of losing *their* sitting balance. The certified nursing assistant also provides lifting assistance as *Resident* J gets onto and off of the tub bench.

   Coding: GG0130E would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as *Resident* J washes, rinses, and dries *them*self. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

2. **Shower/bathe self:** *Resident* E has a severe and progressive neurological condition that has affected *their* endurance as well as *their* fine and gross motor skills. *They are* transferred to the shower bench with partial/moderate assistance. *Resident* E showers while sitting on a shower bench and washes *their* arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of *their* body, as a result of *Resident* E's fatigue, to complete the activity. *Resident* E uses a hand-held showerhead to rinse *them*self but tires halfway through the task. The certified nursing assistant dries *Resident* E's entire body.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper assists *Resident* E with more than half of the task of showering, which includes bathing, rinsing, and drying *their* body. The transfer onto the shower bench is not considered in coding this activity.

3. **Shower/bathe self:** *Resident* Y has limited mobility resulting from *their* multiple and complex medical conditions. *They* prefer to wash *their* body while sitting in front of the sink in *their* bathroom. A helper assists with washing, rinsing, and drying *Resident* Y's arms/hands, upper legs, lower legs, buttocks, and back.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper completed more than half the activity. Bathing may occur at the sink. When coding this activity, do not include assistance provided with washing, rinsing, or drying the resident's back.

Draft

GG0130: Self-Care (cont.)

Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses *them*self and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.
- The following items are considered a piece of clothing when coding the dressing items:
  - Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
  - Lower body dressing examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.
  - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
- *If a resident requires assistance with dressing, including assistance with buttons, fasteners and/or fastening a bra, code based on the type and amount of assistance required to complete the entire dressing activity.*
- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.
- For residents with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  - If the resident performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.

Draft

GG0130: Self-Care (cont.)

- If the resident did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

- For residents with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  - If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  - If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

1. **Upper body dressing:** *Resident* Y has right-side upper extremity weakness as a result of a stroke and has worked in therapy to relearn how to dress *their* upper body. During the day, *they* require a certified nursing assistant only to place *their* clothing next to *their* bedside. *Resident* Y can now use compensatory strategies to put on *their* bra and top without any assistance. At night *they* remove *their* top and bra independently and put the clothes on the nightstand, and the certified nursing assistant puts them away in *their* dresser.

   Coding: GG0130F would be coded 05, Setup or clean-up assistance.

   Rationale: *Resident* Y dresses and undresses *their* upper body and requires a helper only to retrieve and put away *their* clothing, that is, setting up the clothing for *their* use. The description refers to *Resident* Y as "independent" (when removing clothes), but *they* need setup assistance, so *they are* not independent with regard to the entire activity of upper body dressing.

2. **Upper body dressing:** *Resident* Z wears a bra and a sweatshirt most days while in the SNF. *They* require assistance from a certified nursing assistant to initiate the threading of *their* arms into *their* bra. *Resident* Z completes the placement of the bra over *their* chest. The helper hooks the bra clasps. *Resident* Z pulls the sweatshirt over *their* arms, head, and trunk. When undressing, *Resident* Z removes the sweatshirt, with the helper assisting *them* with one sleeve. *Resident* Z slides the bra off, once it has been unclasped by the helper.

   Coding: GG0130F would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides assistance with threading *Resident* Z's arms into *their* bra and hooking and unhooking *their* bra clasps and assistance with removing one sleeve of the sweatshirt. *Resident* Z performs more than half of the effort.

GG0130: Self-Care (cont.)

3. **Upper body dressing:** *Resident* K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. *They* place *their* left hand into one-third of *their* left sleeve of *their* shirt with much time and effort and *are* unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for *Resident* K.

   Coding: GG0130F would be coded 02, Substantial/maximal assistance.

   Rationale: *Resident* K can perform a small portion of the activity of upper body dressing but requires assistance by a helper for more than half of the effort of upper body dressing.

Examples for GG0130G, Lower body dressing

1. **Lower body dressing:** *Resident* D is required to follow hip precautions as a result of recent hip surgery. The occupational therapist in the acute care hospital instructed *them* in the use of adaptive equipment to facilitate lower body dressing. *They* require a helper to retrieve *their* clothing from the closet. *Resident* D uses *their* adaptive equipment to assist in threading *their* legs into *their* pants. Because of balance issues, *Resident* D needs the helper to steady *them* when standing to manage pulling on or pulling down *their* pants/undergarments. *Resident* D also needs some assistance to put on and take off *their* socks and shoes.

   Coding: GG0130G would be coded 04, Supervision or touching assistance.

   Rationale: A helper steadies *Resident* D when *they are* standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.

2. **Lower body dressing:** *Resident* M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. *They have* been issued a knee brace, to be worn during the day. *Resident* M threads *their* legs into *their* garments and pulls up and down *their* clothing to and from just below *their* hips. Only a little assistance from a helper is needed to pull up *their* garments over *their* hips. *Resident* M requires the helper to fasten *their* knee brace because of grasp and fine motor weakness.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.

   Rationale: A helper provides only a little assistance when *Resident* M is putting on *their* lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace *they* wear is considered when determining the help needed when coding lower body dressing.

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GG0130: Self-Care (cont.)

3. **Lower body dressing:** *Resident* R has peripheral neuropathy in *their* upper and lower extremities. Each morning, *Resident* R needs assistance from a helper to place *their* lower limb into, or to take it out of (don/doff), *their* lower limb prosthesis. *They* need no assistance to put on and remove *their* underwear or slacks.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.

   Rationale: A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports *Resident* R's trunk or limbs, but provides less than half the effort for the task of lower body dressing.

Examples for GG0130H, Putting on/taking off footwear

1. **Putting on/taking off footwear:** *Resident* M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. *They have* made significant progress toward *their* independence and will be discharged to home tomorrow. *Resident* M wears an ankle-foot orthosis that *they* put on *their* foot and ankle after *they* put on *their* socks but before *they* put on *their* shoes. *They* always place *their* AFO, socks, and shoes within easy reach of *their* bed. While sitting on the bed, *they* need to bend over to put on and take off *their* AFO, socks, and shoes, and *they* occasionally lose *their* sitting balance, requiring staff to place their hands on *them* to maintain *their* balance while performing this task.

   Coding: GG0130H would be coded 04, Supervision or touching assistance.

   Rationale: *Resident* M puts on and takes off *their* AFO, socks, and shoes by *them*self; however, because of occasional loss of balance, *they* need a helper to provide touching assistance when *they are* bending over.

2. **Putting on/taking off footwear:** *Resident* F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. *They* require setup for retrieving *their* socks and shoes, which *they* prefer to keep in the closet. *Resident* F often drops *their* shoes and socks as *they* attempt to put them onto *their* feet or as *they* take them off. Often a certified nursing assistant must first thread *their* socks or shoes over *their* toes, and then *Resident* F can complete the task. *Resident* F needs the certified nursing assistant to initiate taking off *their* socks and unstrapping the fasten*ers on their* shoes.

   Coding: GG0130H would be coded 02, Substantial/maximal assistance.

   Rationale: A helper provides *Resident* F with assistance in initiating putting on and taking off *their* footwear because of *their* limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

GG0130: Self-Care (cont.)

Coding Tips for GG0130I, Personal hygiene

- *Complete GG0130I when A0310A = 01 – 06 or A0310F = 10 or 11.*
- *Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (excludes baths, showers, and oral hygiene).*

Examples for GG0130I, Personal hygiene

1. *A certified nursing assistant takes Resident L's comb, razor, and shaving cream from the drawer and places them at the bathroom sink. Resident L combs their hair and shaves daily. During the observation period, they required cueing to complete their shaving tasks.*

   Coding: *GG01301 would be coded 04, Supervision or touching assistance.*
   Rationale: *A certified nursing assistant placed grooming devices at sink for the resident's use and provided cueing during the observation period.*

2. *Resident J is unable to brush and style their hair or wash and dry their face due to elbow pain. A certified nursing assistant completes these tasks for them.*

   Coding: *GG0130I would be coded 02, Substantial/moderate assistance.*
   Rationale: *Resident J was unable to complete their personal hygiene and required a certified nursing assistant to complete their personal hygiene tasks during the assessment period. The certified nursing assistant provided more than half the effort to complete the personal hygiene tasks.*

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GG0130: Self-Care (cont.)

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident's eating abilities:

   Nurse: "Please describe to me how *Resident* S eats *their* meals. Once the food and liquid are presented to *them*, do *they* use utensils to bring food to *their* mouth and swallow?"

   Certified nursing assistant: "No, I have to feed *them*."

   Nurse: "Do you always have to physically feed *them* or can *they* sometimes do some aspect of the eating activity with encouragement or cues to feed *them*self?"

   Certified nursing assistant: "No, *they* can't do anything by *them*self. I scoop up each portion of the food and bring the fork or spoon to *their* mouth. I try to encourage *them* to feed *them*self or to help guide the spoon to *their* mouth but *they* can't hold the fork. I even tried encouraging *them* to eat food *they* could pick up with *their* fingers, but *they* will not eat unless *they are* completely assisted for food and liquid."

   In this example, the nurse inquired specifically how *Resident* S requires assistance to eat *their* meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, *they* may not have received enough information to make an accurate assessment of the assistance *Resident* S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

   Coding: GG0130A would be coded 01, Dependent.
   Rationale: The resident requires complete assistance from the certified nursing assistant to eat *their* meals.

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident's oral hygiene score and a certified nursing assistant regarding the resident's oral hygiene routine:

   Nurse: "Does *Resident* K help with brushing *their* teeth?"

   Certified nursing assistant: "*They* can help clean *their* teeth."

   Nurse: "How much help do *they* need to brush *their* teeth?"

   Certified nursing assistant: "*They* usually get tired after starting to brush *their* upper teeth. I have to brush most of *their* teeth."

   In this example, the nurse inquired specifically how *Resident* K manages *their* oral hygiene. The nurse asked about physical assistance and how the resident performed the activity. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* K received.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The certified nursing assistant provides more than half the effort to complete *Resident* K's oral hygiene.

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GG0130: Self-Care (cont.)

Discharge Goals: Coding Tips

Discharge goals are coded with each Admission assessment when A0310B = 01, indicating the start of a PPS stay. Discharge goals are not required with stand-alone OBRA assessments.

- For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. *Identifying multiple goals helps to ensure that the assessment accurately reflects resident status and facilitates person-centered individualized care planning.* Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.
- Licensed, qualified clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, *practice standards,* expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.
- If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a Discharge Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

Discharge Goal: Coding Examples

1. Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code

If the qualified clinician determines that the resident is expected to make gains in function by discharge, the code reported for Discharge Goal will be higher than the admission performance code.

GG0130: Self-Care (cont.)

2. Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain *their* admission functional performance level. The qualified clinician discusses functional status goals with the resident and *their* family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident's admission performance code.

Oral Hygiene 5-Day PPS Assessment Admission Performance: In this example, the qualified clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident's 5-Day PPS admission performance code is coded and the Discharge Goal is coded at the same level. *Resident* E has stated *their* preference for participation twice daily in *their* oral hygiene activity. *Resident* E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The qualified clinician observes *Resident* E's 5-Day PPS admission performance and discusses *their* usual performance with qualified clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting *Resident* E's limb). The qualified clinician codes *Resident* E's 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding *their* limb.

Oral Hygiene 5-Day PPS Assessment Discharge Goal: The qualified clinician anticipates *Resident* E's discharge performance will remain 02, Substantial/maximal assistance. Due to *Resident* E's progressive and degenerative condition, the qualified clinician and resident feel that, while *Resident* E is not expected to make gains in oral hygiene performance, maintaining *their* function at this same level is desirable and achievable as a Discharge Goal.

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GG0130: Self-Care (cont.)

3. Discharge Goal Code Is *Lower* than 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the Discharge Goal code is lower than the resident's 5-Day PPS assessment admission performance code.

Toileting Hygiene: *Resident* T's participation in skilled therapy is expected to slow down the pace of *their* anticipated functional deterioration. The resident's Discharge Goal code will be lower than the 5-Day PPS Admission Performance code.

Toileting Hygiene 5-Day PPS Assessment Admission Performance: *Resident* T has a progressive neurological illness that affects *their* strength, coordination, and endurance. *Resident* T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports *Resident* T while *they are* standing so that *Resident* T can release *their* hand from the grab bar (next to *their* bedside commode) and pull down *their* underwear before sitting onto the bedside commode. When *Resident* T has finished voiding, *they* wipe *their* perineal area. *Resident* T then requires the helper to support *their* trunk while *Resident* T pulls up *their* underwear. The qualified clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for *Resident* T's toileting hygiene.

Toileting Hygiene Discharge Goal: By discharge, it is expected that *Resident* T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The qualified clinician codes *their* Discharge Goal as 02, Substantial/maximal assistance.

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GG0170: Mobility (3-day assessment period) Admission

GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support.
		D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to get on and off a toilet or commode.
		FF. Tub/shower transfer: The ability to get in and out of a tub/shower.
		G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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GG0170: Mobility (3-day assessment period) Admission (cont.)

GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ **Q1. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

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GG0170: Mobility (3-day assessment period) Discharge

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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GG0170: Mobility (3-day assessment period) Discharge (cont.)

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐ **Q3. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

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GG0170: Mobility (OBRA/Interim)

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)
Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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GG0170: Mobility (OBRA/Interim) (cont.)

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)
Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓		
	☐	**Q5. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	
	☐	**RR5. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.	
	☐	**SS5. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

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GG0170: Mobility (cont.)

Item Rationale

- *R*esidents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the *facility*. *Please review the item rationale for GG0130, Self-Care, for additional information about the importance of assessing ADLs, including information about health-related quality of life and planning for care.*

Steps for Assessment

1. Assess the resident's mobility performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.
   - For *residents in a Medicare Part A stay,* the admission assessment period is the first *3* days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. *The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.*
     - ***Note:*** *If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B and both columns are required. In these scenarios, do not complete Column 5. OBRA/Interim Performance.*
   - For *residents in a Medicare Part A stay, the assessment period for* the Interim Payment Assessment (A0310B = 08) is the last 3 days (i.e., the ARD *plus 2 pervious calendar* days).
   - *For residents in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus 2 previous calendar days. For all other Discharge assessments, the assessment period is A2000, Discharge Date plus 2 previous calendar days.*
   - *When completing an OBRA-required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.*
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

DEFINITION

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

GG0170: Mobility (cont.)

3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. *For residents in a Medicare Part A stay, t*he admission functional assessment, when possible, should be conducted prior to the resident benefitting from treatment interventions in order to reflect the resident's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

Coding Instructions

- When coding the resident's usual performance and the resident's discharge goal(s), use the six-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by *them*self with no assistance from a helper.
- **Code 05, 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 placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.
- **Code 04, 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. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.
- **Code 03, 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. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.

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GG0170: Mobility (cont.)

- **Code 02, 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.
- **Code 01, 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.
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.
- For additional information on coding the resident's performance on the assessment instrument, refer to the Decision Tree on page GG-1*8*.

Coding Tips

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay. *Additionally, an OBRA Admission assessment (A0310A = 1) is required for a new resident and, under some circumstances, a returning resident and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA Admission assessment.*
  - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (*3* calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
  - *For an OBRA Admission assessment, code the resident's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.*

GG0170: Mobility (cont.)

- ***OBRA/*Interim:**
  - The Interim Payment Assessment (IPA) *(A0310B = 08)* is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.
  - *OBRA assessments (A0310A = 01 – 06) are required for residents in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual.*
  - For Section GG on the IPA *or an OBRA assessment*, providers will use the same 6-point scale and activity not attempted codes to *assess the resident's usual functional status during the 3-day assessment period*.
  - The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD *plus* 2 *previous* calendar days). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
  - *For Section GG on OBRA assessments other than the Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days).*
- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A stay ends as documented in A2400C, End of Most Recent Medicare Stay, either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000). *An OBRA Discharge assessment is required when the resident is discharged from the facility.* Please see Chapter 2 and Section A of the RAI Manual for additional details regarding Discharge assessments.
  - For the Discharge assessment, (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.
  - *On standalone OBRA Discharge assessments (i.e., A0310F = 10 or 11 AND A0310H = 0), code the resident's usual performance during last 3 days of their stay (i.e., A2000, Discharge Date plus 2 previous calendar days).*

GG0170: Mobility (cont.)

Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the resident walks 50 feet and negotiates two turns.
- *Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident's need for assistance to perform the activity safely (for example, fall risk due to increased mobility activities).*
- An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a resident's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG *and* should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.
- *CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.*
- *Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).*

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GG0170: Mobility (cont.)

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG is based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire assessment period to obtain the resident's usual performance.

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GG0170: Mobility (cont.)

Examples and Coding Tips

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Coding Tip for GG0170A, Roll left and right

- *If the resident does not sleep in a bed, clinicians should assess bed mobility activities using the alternative furniture on which the resident sleeps (for example, a recliner).*

Examples for GG0170A, Roll left and right

1. **Roll left and right:** *Resident* R has a history of skin breakdown. A nurse instructs *them* to turn onto *their* right side, providing step-by-step instructions to use the bedrail, bend *their* left leg, and then roll onto *their* right side. *Resident* R attempts to roll with the use of the bedrail, but indicates *they* cannot perform the task. The nurse then rolls *them* onto *their* right side. Next, *Resident* R is instructed to return to lying on *their* back, which *they* successfully complete. *Resident* R then requires physical assistance from the nurse to roll onto *their* left side and to return to lying on *their* back to complete the activity.

   Coding: GG0170A would be coded 02, Substantial/maximal assistance.
   Rationale: The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right. This is because the nurse provides physical assistance to move *Resident* R's body weight to turn onto *their* right side. The nurse provides the same assistance when *Resident* R turns to *their* left side and when *they* return to *their* back. *Resident* R is able to return to lying on *their* back from *their* right side by *them*self.

2. **Roll left and right:** A physical therapist helps *Resident* K turn onto *their* right side by instructing *them* to bend *their* left leg and roll onto *their* right side. *The physical therapist* then instructs *them* on how to position *their* limbs to return to lying on *their* back and then to repeat a similar process for rolling onto *their* left side and then return to lying on *their* back. *Resident* K completes the activity without physical assistance from the physical therapist.

   Coding: GG0170A would be coded 04, Supervision or touching assistance.
   Rationale: The physical therapist provides verbal cues (i.e., instructions) to *Resident* K as *they* roll from *their* back to *their* right side and return to lying on *their* back, and then again as *they* perform the same activities with respect to *their* left side. The physical therapist does not provide any physical assistance.

GG0170: Mobility (cont.)

3. **Roll left and right:** *Resident* Z had a stroke that resulted in paralysis on *their* right side and is recovering from cardiac surgery. *They* require the assistance of two certified nursing assistants when rolling onto *their* right side and returning to lying on *their* back and also when rolling onto *their* left side and returning to lying on *their* back.

   Coding: GG0170A would be coded 01, Dependent.
   Rationale: Two certified nursing assistants are needed to help *Resident* Z roll onto *their* left and right side and back while in bed.

4. **Roll left and right:** *Resident* M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician's order allows *them* to roll onto *their* left hip as tolerated. A certified nursing assistant assists *Resident* M in rolling onto *their* right side by instructing *them* to bend *their* left leg while rolling to *their* right side. *Resident* M needs physical assistance from the certified nursing assistant to initiate *their* rolling right because of *their* left arm weakness when grasping the right bedrail to assist in rolling. *Resident* M returns to lying on *their* back without assistance and uses *their* right arm to grasp the left bedrail to slowly roll onto *their* left hip and then return to lying on *their* back.

   Coding: GG0170A would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

Examples for GG0170B, Sit to lying

1. **Sit to lying:** *Resident* H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on *their* right side. The helper lifts and positions *Resident* H's right leg. *Resident* H uses *their* arms to position *their* upper body and lowers *them*self to a lying position flat on *their* back.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts *Resident* H's right leg and helps *them* position it as *they* move from a seated to a lying position; the helper performs less than half of the effort.

2. **Sit to lying:** *Resident* F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of *their* right hip and left and right wrists. The certified nursing assistant cradles and supports *their* trunk and right leg to transition *Resident* F from sitting at the side of the bed to lying flat on the bed. *Resident* F assists *them*self a small amount by bending *their* elbows and left leg while pushing *their* elbows and left foot into the mattress only to straighten *their* trunk while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

GG0170: Mobility (cont.)

3. **Sit to lying:** *Resident* H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on *their* right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to *Resident* H each step of the sitting to lying activity. *Resident* H is then fully assisted to get from sitting to a lying position on the bed. *Resident* H makes no attempt to assist when asked to perform the incremental steps of the activity.

   Coding: GG0170B would be coded 01, Dependent.

   Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Sit to lying:** *Resident* F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). *They* can maneuver *them*self when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

   Coding: GG0170B would be coded 04, Supervision or touching assistance.

   Rationale: A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.

5. **Sit to lying:** *Resident* A suffered multiple vertebral fractures due to a fall off a ladder. *They* require assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in *their* lower back. The therapist supports *their* trunk and lifts both legs to assist *Resident* A from sitting at the side of the bed to lying flat on the bed. *Resident* A assists *them*self a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

Coding Tips for GG0170C, Lying to sitting on side of bed

- The activity includes resident transitions from lying on *their* back to sitting on the side of the bed without back support. The residents' ability to perform each of the tasks within this activity and how much support the residents require to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular resident.
- Back support refers to an object or person providing support for the resident's back.
- If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

GG0170: Mobility (cont.)

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** *Resident* B pushes up from the bed to get *them*self from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as *Resident* B scoots *them*self to the edge of the bed and lowers *their* feet onto the floor.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance as the resident moves from a lying to sitting position.

2. **Lying to sitting on side of bed:** *Resident* B pushes up on the bed to attempt to get *them*self from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for *them* to sit upright. The occupational therapist provides additional lifting assistance as *Resident* B scoots *them*self to the edge of the bed and lowers *their* feet to the floor.

   Coding: GG0170C would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** *Resident* P is being treated for sepsis and has multiple infected wounds on *their* lower extremities. Full assistance from the certified nursing assistant is needed to move *Resident* P from a lying position to sitting on the side of *their* bed because *they* usually *have* pain in *their* lower extremities upon movement.

   Coding: GG0170C would be coded 01, Dependent.

   Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the resident.

4. **Lying to sitting on side of bed:** *Resident* P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies *Resident* P's trunk as *they* get to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. *Resident* P then scoots toward the edge of the bed and places both feet flat on the floor. *Resident* P completes most of the effort to get from lying to sitting on the side of the bed.

   Coding: GG0170C would be coded 03, Partial/moderate assistance.

   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of lying to sitting on side of bed.

Draft

GG0170: Mobility (cont.)

Coding Tips for GG0170D, Sit to stand

- *The activity includes the resident coming to a standing position from any sitting surface.*
- If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.
- *If a full-body mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer, code GG0170D, Sit to stand with the appropriate "activity not attempted" code.*
- *Code as 05, Setup or clean-up assistance, if the only help a resident requires to complete the sit-to-stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle-foot orthosis.*

Examples for GG0170D, Sit to stand

1. **Sit to stand:** *Resident* M has osteoarthritis and is recovering from sepsis. *Resident* M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on *Resident* M's trunk.

   Coding: GG0170D would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance only.

2. **Sit to stand:** *Resident* L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist *them* to stand up from sitting in a chair.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: *Resident* L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** *Resident* B has complete tetraplegia and is currently unable to stand when getting out of bed. *They* transfer from *their* bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to *their* medical condition.

   Coding: GG0170D would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The activity is not attempted due to the resident's diagnosis of complete tetraplegia.

Draft

GG0170: Mobility (cont.)

4. **Sit to stand:** *Resident* Z has amyotrophic lateral sclerosis with moderate weakness in *their* lower and upper extremities. *Resident* Z has prominent foot drop in *their* left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies *Resident* Z's AFO and places the platform walker in front of *them*; *Resident* Z uses the walker to steady *them*self once standing. The certified nursing assistant provides lifting assistance to get *Resident* Z to a standing position and must also provide assistance to steady *Resident* Z's balance to complete the activity.

   Coding: GG0170D would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

5. **Sit to stand:** *Resident* R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings *Resident* R *their* crutches and helps *them* to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get *Resident* R to a standing position but provides less than half the effort to complete the activity.

   Coding: GG0170D would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

Coding Tips for GG0170E, Chair/bed-to-chair transfer

- *Depending on the resident's abilities, the transfer may be a stand-pivot, squat-pivot, or a slide board transfer.*
- *For item GG0170E, Chair/bed-to-chair transfer:*
  - *When assessing the resident moving from the chair/bed to the chair, the assessment begins with the resident sitting at the edge of the bed (or alternative sleeping surface) and ends with the resident sitting in a chair or wheelchair.*
  - *When assessing the resident moving from the chair to the bed, the assessment begins with the resident sitting in a chair or wheelchair and ends with the resident returning to sitting at the edge of the bed (or alternative sleeping surface).*
  - *The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.*
- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.
- *When possible, the transfer should be assessed in an environmental situation in which taking more than a few steps would not be necessary to complete the transfer.*

Draft

GG0170: Mobility (cont.)

Examples for GG0170E, Chair/bed-to-chair transfer

1. **Chair/bed-to-chair transfer:** *Resident* L had a stroke and currently is not able to walk. *They* use a wheelchair for mobility. When *Resident* L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that *Resident* L can transfer into the wheelchair safely. *Resident* L had been observed several other times to determine any safety concerns, and it was documented that *they* transfer safely without the need for supervision. *Resident* L transfers into the wheelchair by *them*self (no helper) after the certified nursing assistant leaves the room.

   Coding: GG0170E would be coded 05, Setup or clean-up assistance.

   Rationale: *Resident* L is not able to walk, so *they* transfer from *their* bed to a wheelchair when getting out of bed. The helper provides setup assistance only. *Resident* L transfers safely and does not need supervision or physical assistance during the transfer.

2. **Chair/bed-to-chair transfer:** *Resident* C is sitting on the side of the bed. *They* stand and pivot into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time *Resident* C only required verbal cues for safety, but usually *Resident* C requires touching assistance.

   Coding: GG0170E would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance during the transfers.

3. **Chair/bed-to-chair transfer:** *Resident* F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and *they* recently underwent bilateral above-the-knee amputations. *Resident* F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer *Resident* F from the bed to a wheelchair. *Resident* F is unable to assist in the transfer from *their* bed to the wheelchair.

   Coding: GG0170E would be coded 01, Dependent.

   Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Chair/bed-to-chair transfer:** *Resident* P has metastatic bone cancer, severely affecting *their* ability to use *their* lower and upper extremities during daily activities. *Resident* P is motivated to assist with *their* transfers from the side of *their* bed to the wheelchair. *Resident* P pushes *them*self up from the bed to begin the transfer while the therapist provides limited trunk support with weight-bearing assistance. Once standing, *Resident* P shuffles *their* feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance.

   Coding: GG0170E would be coded 03, Partial/moderate assistance.

   Rationale: The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

Draft

GG0170: Mobility (cont.)

5. **Chair/bed-to-chair transfer:** *Resident* U had *their* left lower leg amputated due to gangrene associated with *their* diabetes mellitus and *they have* reduced sensation and strength in *their* right leg. *They have* not yet received *their* below-the-knee prosthesis. *Resident* U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under *their* buttock. *Resident* U then attempts to scoot from the bed onto the transfer board. *Resident* U has reduced sensation in *their* hands and limited upper body strength, but assists with the transfer. The physical therapist assists *them* in side scooting by lifting *their* buttocks/trunk in a rocking motion across the transfer board and into the wheelchair.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

Coding Tips for GG0170F, Toilet transfer

- *Toilet transfer includes the resident's ability to get on and off a toilet (with or without a raised toilet seat) or bedside commode.*
- *Toileting hygiene, clothing management, and transferring on and off a bedpan are not considered part of the Toilet transfer activity.*
- *Code as 05, Setup or clean-up assistance, if the resident requires a helper to position/set up the bedside commode before and/or after the resident's bed-to-commode transfers (place at an accessible angle/location next to the bed) and the resident does not require helper assistance during Toilet transfers.*

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that *Resident* T can transfer from the wheelchair onto the toilet by *them*self safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once *Resident* T completes the transfer from the toilet back to the wheelchair, *they* flip the footrests back down *them*self.

   Coding: GG0170F would be coded 05, Setup or clean-up assistance.

   Rationale: The helper provides setup assistance (moving the footrest out of the way) before *Resident* T can transfer safely onto the toilet.

Draft

GG0170: Mobility (cont.)

2. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as *Resident* Z lowers *their* underwear and then transfers onto the toilet. After voiding, *Resident* Z cleanses *them*self. *They* then stand up as the helper steadies *them* and *Resident* Z pulls up *their* underwear as the helper steadies *them* to ensure *Resident* Z does not lose *their* balance.

   Coding: GG0170F would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides steadying assistance as the resident transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene and is not considered when rating the Toilet transfer item.

3. **Toilet transfer:** The therapist supports *Resident* M's trunk with a gait belt by providing weight-bearing as *Resident* M pivots and lowers *them*self onto the toilet.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

4. **Toilet transfer:** *Resident* W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. *Resident* W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. *Resident* W initiates lifting *their* buttocks from the bed and in addition requires some of *their* weight to be lifted by the certified nursing assistant to stand upright. *Resident* W then reaches and grabs onto the armrest of the bedside commode to steady *them*self. The certified nursing assistant provides weight-bearing assistance as *they* slowly rotate and lower *Resident* W onto the bedside commode.

   Coding: GG0170F would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half of the effort for the resident to complete the activity of toilet transfer.

5. **Toilet transfer:** *Resident* H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. *Resident* H prefers to use the bedside commode when moving *their* bowels. Due to *their* severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

   Coding: GG0170F would be coded 01, Dependent.

   Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.

6. **Toilet transfer:** *Resident* S is on bedrest due to a medical complication. *They* use a bedpan for bladder and bowel management.

   Coding: GG0170F would be coded 88, Not attempted due to medical condition or safety concerns.

   Rationale: The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

GG0170: Mobility (cont.)

Coding Tips for GG0170FF, Tub/shower transfer

- *Complete GG0170FF when A0310A = 01 – 06 or A0310F = 10 or 11.*
- *Tub/shower transfers involve the ability to get into and out of the tub or shower. Do not include washing, rinsing, drying, or any other bathing activities in this item.*
- *If the resident does not get into or out of a tub and/or shower during the observation period, use one of the "activity not attempted" codes (07, 09, 10, or 88).*

Examples for GG0170FF, Tub/shower transfer

1. *During the observation period, Resident M took one shower. They received physical help from two staff members to get into and out of the shower.*

   Coding: *GG0170FF would be coded 01. Dependent.*
   Rationale: *Resident M required two staff members to assist with shower transfers during the observation period. This represents their usual performance of this activity during the observation period.*

2. *On Monday, Resident Q required trunk support from one certified nursing assistant to get into and out of the tub. On Wednesday, day 3 of the assessment period, Resident Q required trunk support from one certified nursing assistant to get into the tub and needed assistance lifting their legs during the transfer out of the tub. No other tub or shower transfers occurred during the observation period.*

   Coding: *GG0170FF would be coded 03. Partial/moderate assistance.*
   Rationale: *Resident Q participated in four tub transfers (two transfers into the tub and two transfers out of the tub) during the observation period. They required trunk support for three transfers and required the helper to lift their legs for one transfer. Because the helper performed less than half the effort for three of the four transfers, Resident Q's usual performance is 03. Partial/moderate assistance.*

Draft

GG0170: Mobility (cont.)

Coding Tips for GG0170G, Car transfer

- For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers.
- The Car transfer does not include *getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seat belt.*
- *If the resident remains in a wheelchair and does not transfer in and out of a car or van seat, then the activity is not considered completed, and the appropriate "activity not attempted" code would be used.*
- *The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the Car transfer activity.*
- In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire assessment period, then use code 10, Not attempted due to environmental limitations.
- If at the time of the assessment the resident is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.

Examples for GG0170G, Car transfer

1. **Car transfer:** *Resident* W uses a wheelchair and ambulates for only short distances. *They* require lifting assistance from a physical therapist to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when *Resident* W takes several steps during the transfer turn. *Resident* W lowers *them*self into the car seat with steadying assistance from the therapist. *They* lift *their* legs into the car with support from the therapist.

   Coding: GG0170G would be coded 02, Substantial/maximal assistance.

   Rationale: Although *Resident* W also contributes effort to complete the activity, the helper contributed more than half the effort needed to transfer *Resident* W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** During *their* rehabilitation stay *Resident* N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, *Resident* N requires verbal reminders for safety and light touching assistance. The therapist instructs *them* on strategic hand placement while *Resident* N transitions to sitting in the car's passenger seat. The therapist opens and closes the door.

   Coding: GG0170G would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance as the resident transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

GG0170: Mobility (cont.)

Coding Tips for GG0170I–G0170L Walking Items

- *Assessment of the walking activities starts with the resident in a standing position.*
- *A walking activity cannot be completed without some level of resident participation that allows resident ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a resident.*
- *During a walking activity, a resident may take a brief standing rest break. If the resident needs to sit to rest during a Section GG walking activity, consider the resident unable to complete the walking activity and use the appropriate activity not attempted code.*
- *Clinicians can use clinical judgment to determine how the actual resident assessment of walking is conducted. If a clinician chooses to combine the assessment of multiple walking activities, the clinician should use clinical judgment to determine the type and amount of assistance needed for each individual activity.*
- *Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity.*
- Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
- When coding GG0170 walking items, **do not** consider the resident's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
- The turns included in item GG0170J, Walk 50 feet with two turns, are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).
- *When coding GG0170K, Walk 150 feet, if the resident's environment does not accommodate a walk of 150 feet without turns, but the resident demonstrates the ability to walk, with or without assistance, 150 feet with turns without jeopardizing the resident's safety, code using the 6-point scale.*
- *When coding GG0170L, Walking 10 feet on uneven surfaces, the activity can be assessed inside or outside. Examples of uneven surfaces include uneven or sloping surfaces, turf, and gravel. Use clinical judgment to determine whether a surface is uneven.*

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** *Resident* C has resolving sepsis and has not walked in three weeks because of *their* medical condition. A physical therapist determines that it is unsafe for *Resident* C to use a walker, and the resident only walks using the parallel bars. On day 3 of the Admission assessment period, *Resident* C walks 10 feet using the parallel bars while the therapist provides substantial weight-bearing support throughout the activity.

GG0170: Mobility (cont.)

Coding: GG0170I would be coded 88, Not attempted due to medical condition or safety concerns.
Rationale: When assessing a resident for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the resident is unable to walk without the use of parallel bars because of *their* medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns.

2. **Walk 10 feet:** *Resident* L had bilateral amputations three years ago, and prior to the current admission *they* used a wheelchair and did not walk. Currently *Resident* L does not use prosthetic devices and uses only a wheelchair for mobility. *Resident* L's care plan includes fitting and use of bilateral lower extremity prostheses.

   Coding: GG0170I would be coded 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
   Rationale: When assessing a resident for GG0170I, Walk 10 feet, consider the resident's status prior to the current episode of care and current assessment status. Use code 09, Not applicable, because *Resident* L did not walk prior to the current episode of care and did not walk during the assessment period. *Resident* L's care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the resident's care plan.

3. **Walk 10 feet:** *Resident* C has Parkinson's disease and walks with a walker. A physical therapist must advance the walker for *Resident* C with each step. The physical therapist assists *Resident* C by physically initiating the stepping movement forward, advancing *Resident* C's foot, during the activity of walking 10 feet.

   Coding: GG0170I would be coded 02, Substantial/maximal assistance.
   Rationale: A helper provides more than half the effort as the resident completes the activity.

4. **Walk 10 feet:** *Resident* O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. A physical therapist assistant guides and steadies the shaking, rolling walker forward while cueing *Resident* O to take larger steps. *Resident* O requires steadying at the beginning of the walk and progressively requires some of *their* weight to be supported for the last two feet of the 10-foot walk.

   Coding: GG0170I would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort required for the resident to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, *Resident* O supported *their* own body weight with *their* arms and legs and propelled *their* legs forward for 8 of the 10 feet. The helper supported part of *Resident* O's weight only for 2 of the 10 feet; thus *Resident* O contributed more than half the effort.

GG0170: Mobility (cont.)

5. **Walk 10 feet:** *Resident* U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned *their* stump sock and prosthesis, *Resident* U is assisted to stand and uses *their* rolling walker while walking. The nurse places *their* hand on *Resident* U's back to steady *them* toward the last half of *their* 10-foot walk.

   Coding: GG0170I would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance in order for the resident to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as *Resident* W gets up from a sitting position to a standing position. After the therapist places *Resident* W's walker within reach, *Resident* W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while *they* walk.

   Coding: GG0170J would be coded 05, Setup or clean-up assistance.
   Rationale: *Resident* W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D, Sit to stand (04, Supervision or touching assistance).

2. **Walk 50 feet with two turns:** *Resident* P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when *Resident* P turns.

   Coding: GG0170J would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.

3. **Walk 50 feet with two turns:** *Resident* L is unable to bear *their* full weight on *their* left leg. As *they* walk 60 feet down the hall with *their* crutches and make two turns, the certified nursing assistant supports *their* trunk providing weight-bearing assistance.

   Coding: GG0170J would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** *Resident* T walks 50 feet with the therapist providing trunk support. *They* also require a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety. *Resident* T walks the 50 feet with two turns with the assistance of two helpers.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: *Resident* T requires two helpers to complete the activity.

Draft

GG0170: Mobility (cont.)

5. **Walk 50 feet with two turns:** *Resident* U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. *Resident* U is assisted to stand and, after walking 10 feet, requires progressively more help as *they* near the 50-foot mark. *Resident* U is unsteady and typically loses *their* balance when turning, requiring significant support to remain upright. The therapist provides significant trunk support for about 30 to 35 feet.

   Coding: GG0170J would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

Examples for GG0170K, Walk 150 feet

1. **Walk 150 feet:** *Resident* D walks down the hall using *their* walker and the certified nursing assistant usually needs to provide touching assistance to *Resident* D, who intermittently loses *their* balance while *they* use the walker.

   Coding: GG0170K would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance intermittently throughout the activity.

2. **Walk 150 feet:** *Resident* R has endurance limitations due to heart failure and has only walked about 30 feet during the assessment period. *They have* not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with *Resident* R. The therapist speculates that *Resident* R could walk this distance in the future with additional assistance.

   Coding: GG0170K would be coded 88, *N*ot attempted due to medical condition or safety concerns, and the resident's ability to walk a shorter distance would be coded in item GG0170I.

   Rationale: The activity was not attempted. *The resident did not complete the activity, and a helper cannot complete the activity for the resident. A resident who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.*

3. **Walk 150 feet:** *Resident* T has an unsteady gait due to balance impairment. *Resident* T walks the length of the hallway using *their* quad cane in *their* right hand. The physical therapist supports *their* trunk, helping *them* to maintain *their* balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

   Coding: GG0170K would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** *Resident* W, who has Parkinson's disease, walks the length of the hallway using *their* rolling walker. The physical therapist provides trunk support and advances *Resident* W's right leg in longer strides with each step. The therapist occasionally prevents *Resident* W from falling as *they* lose *their* balance during the activity.

Draft

GG0170: Mobility (cont.)

Coding: GG0170K would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

Example for GG0170L, Walking 10 feet on uneven surfaces

1. **Walking 10 feet on uneven surfaces:** *Resident* N has severe joint degenerative disease and is recovering from sepsis. Upon discharge *Resident* N will need to be able to walk on the uneven and sloping surfaces of *their* driveway. During *their* SNF stay, a physical therapist takes *Resident* N outside to walk on uneven surfaces. *Resident* N requires the therapist's weight-bearing assistance less than half the time during walking in order to prevent *Resident* N from falling as *they* navigate walking 10 feet over uneven surfaces.

   Coding: GG0170L would be coded 03, Partial/moderate assistance.

   Rationale: *Resident* N requires a helper to provide weight-bearing assistance several times to prevent *them* from falling as *they* walk 10 feet on uneven surfaces. The helper contributes less than half the effort required for *Resident* N to walk 10 feet on uneven surfaces.

Coding Tips for GG0170M, 1 step (curb); GG0170N, 4 steps; and GG0170O, 12 steps

- *Completing the stair activities indicates that a resident goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance. Getting to and from the stairs is not included when coding the curb or step activities.*
- *Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up the stairs and then down the stairs occurs sequentially, the resident may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps.*
- *If a resident requires a helper to provide total assist (for example, the resident requires total assist from a helper to move up and down over a curb in their wheelchair), code as 01, Dependent.*
- *A resident who uses a wheelchair may be assessed going up and down stairs (including one step or curb) in a wheelchair. Code based on the type and amount of assistance required from the helper.*
- *If, at the time of the assessment, a resident is unable to complete the activity because of a physician-prescribed restriction (for instance, no stair climbing for two weeks) but could perform this activity prior to the current illness, exacerbation, or injury, code 88, Not attempted due to medical condition or safety concern.*

Draft

GG0170: Mobility (cont.)

- *Assess the resident going up and down one step or up and down over a curb. If both are assessed, and the resident's performance going up and down over a curb is different from their performance going up and down one step (e.g., because the step has a railing), code GG0170M, 1 step (curb) based on the activity with which the resident requires the most assistance.*
- *If a resident's environment does not have 12 steps, the combination of going up and down 4 stairs three times consecutively in a safe manner is an acceptable alternative to comply with the intention and meet the requirements of this activity.*

Example for GG0170M, 1 step (curb)

1. **1 step (curb):** *Resident* Z has had a stroke; *they* must be able to step up and down one step to enter and exit *their* home. A physical therapist provides standby assistance as *they* use *their* quad cane to support *their* balance in stepping up one step. The physical therapist provides steadying assistance as *Resident* Z uses *their* cane for balance and steps down one step.

   Coding: GG0170M would be coded 04, Supervision or touching assistance.

   Rationale: A helper provides touching assistance as *Resident* Z completes the activity of stepping up and down one step.

Example for GG0170N, 4 steps

1. **4 steps:** *Resident* J has lower body weakness, and a physical therapist provides steadying assistance when *they* ascend 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as *Resident* J holds the stair railing.

   Coding: GG0170N would be coded 03, Partial/moderate assistance.

   Rationale: A helper provides touching assistance as *Resident* J ascends 4 steps. The helper provides trunk support (more than touching assistance) when *they* descend the 4 steps.

Example for GG0170O, 12 steps

1. **12 steps:** *Resident* Y is recovering from a stroke resulting in motor issues and poor endurance. *Resident* Y's home has 12 stairs, with a railing, and *they* need to use these stairs to enter and exit *their* home. *Their* physical therapist uses a gait belt around *their* trunk and supports less than half of the effort as *Resident* Y ascends and then descends 12 stairs.

   Coding: GG0170O would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half the required effort in providing the necessary support for *Resident* Y as *they* ascend and descend 12 stairs.

Draft

GG0170: Mobility (cont.)

Coding Tips for GG0170P, Picking up object

- *The activity includes the resident bending or stooping from a standing position to pick up a small object, such as a spoon, from the floor.*
- *Picking up the object must be assessed while the resident is in a standing position. If the resident is not able to stand, the activity did not occur, and the appropriate "not attempted" code would be used.*
- *If a standing resident is unable to pick up a small object from the floor, therefore requiring the helper to assist in picking up the object, code as 01, 02, or 03, depending on whether the helper is providing all the effort, more than half of the effort, or less than half of the effort, respectively.*
- *Assistive devices and adaptive equipment may be used, for example, a cane to support standing balance and/or a reacher to pick up the object.*

Examples for GG0170P, Picking up object

1. **Picking up object:** *Resident* P has a neurologic condition that has resulted in balance problems. *They* want to be as independent as possible. *Resident* P lives with *their spouse* and will soon be discharged from the SNF. *They* tend to drop objects and *have* been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. An occupational therapist needs to remind *Resident* P of safety strategies when *they* bend to pick up objects from the floor, and *the occupational therapist* needs to steady *them* to prevent *them* from falling.

   Coding: GG0170P would be coded 04, Supervision or touching assistance.
   Rationale: A helper is needed to provide verbal cues and touching or steadying assistance when *Resident* P picks up an object because of *their* coordination issues.

2. **Picking up object:** *Resident* C has recently undergone a hip replacement. When *they* drop items *they* use a long-handled reacher that *they have* been using at home prior to admission. *They are* ready for discharge and can now ambulate with a walker without assistance. When *they* drop objects from *their* walker basket *they* require a certified nursing assistant to locate *their* long-handled reacher and bring it to *them* in order for *them* to use it. *They* do not need assistance to pick up the object after the helper brings *them* the reacher.

   Coding: GG0170P would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides set-up assistance so that *Resident* C can use *their* long-handled reacher.

Draft

GG0170: Mobility (cont.)

Coding Tips for *GG0170Q,* GG0170R*,* and GG0170S, Wheelchair Items

- The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair *for self-mobilization* prior to admission. Use clinical judgment to determine whether a resident's use of a wheelchair is for self-mobilization as a result of the resident's medical condition or safety.
- *If the resident used a wheelchair for self-mobilization prior to admission to the facility, indicate 1, Yes, to the gateway wheelchair items on the initial assessment in GG0170Q1.*

  The responses for gateway wheelchair items (GG0170Q1*,* GG0170Q3*, and/or GG0170Q5*) do not have to be the same on *subsequent* assessments. *For example, the Admission assessment may indicate that the resident does not use a wheelchair but the subsequent assessment may indicate that the resident uses a wheelchair.*
- If a wheelchair is used for transport purposes only, then GG0170Q1*,* GG0170Q3, *and/or GG0170Q5,* Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.
  - Example of using a wheelchair for transport convenience: A resident is transported in a wheelchair by staff between *their* room and the therapy gym or by family to the facility cafeteria, but the resident is not expected to use a wheelchair after discharge.
- The turns included in item GG0170R (wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.
- *If a resident's environment does not accommodate wheelchair or scooter use for 150 feet without turns, but the resident demonstrates the ability to mobilize a wheelchair or scooter with or without assistance for 150 feet with turns without jeopardizing the resident's safety, code GG0170S, Wheel 150 feet, using the 6-point scale.*
- *For GG0170S, Wheel 150 feet, a helper can assist a resident in completing the required distance in the wheelchair or in making turns if required. When a resident is unable to wheel the entire distance themself, the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.*

Draft

GG0170: Mobility (cont.)

Example for GG0170Q1, Does the resident use a wheelchair/scooter?

1. **Does the resident use a wheelchair/scooter?** On admission, *Resident* T wheels *them*self using a manual wheelchair, but with difficulty due to *their* severe osteoarthritis and COPD.

   Coding: GG0170Q1 would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair *Resident* T uses for GG0170RR1 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.

   Rationale: The resident currently uses a wheelchair. Coding the resident's performance and the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

Examples for GG0170R, Wheel 50 feet with two turns, and GG0170RR, Indicate the type of wheelchair/scooter used

1. **Wheel 50 feet with two turns:** *Resident* M is unable to bear any weight on *their* right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring *Resident* M from the bed into the wheelchair. Once in *their* wheelchair, *Resident* M propels *them*self about 60 feet down the hall using *their* left leg and makes two turns without any physical assistance or supervision.

   Coding: GG0170R would be coded 06, Independent.

   Rationale: The resident wheels *them*self more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

2. **Indicate the type of wheelchair/scooter used:** In the above example *Resident* M used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.

   Rationale: *Resident* M used a manual wheelchair during the assessment period.

3. **Wheel 50 feet with two turns:** *Resident* R is very motivated to use *their* motorized wheelchair with an adaptive throttle for speed and steering. *Resident* R has amyotrophic lateral sclerosis, and moving *their* upper and lower extremities is very difficult. The physical therapist assistant is required to walk next to *Resident* R for frequent readjustments of *their* hand position to better control the steering and speed throttle. *Resident* R often drives too close to corners, becoming stuck near doorways upon turning, preventing *them* from continuing to mobilize/wheel *them*self. The physical therapist assistant backs up *Resident* R's wheelchair for *them* so that *they* may continue mobilizing/wheeling *them*self.

   Coding: GG0170R would be coded 03, Partial/moderate assistance.

   Rationale: The helper provided less than half of the effort for the resident to complete the activity, Wheel 50 feet with two turns.

Draft

GG0170: Mobility (cont.)

4. **Indicate the type of wheelchair/scooter used:** In the above example *Resident* R used a motorized wheelchair during the assessment period.

   Coding: GG0170RR would be coded 2, Motorized.
   Rationale: *Resident* R used a motorized wheelchair during the assessment period.

5. **Wheel 50 feet with two turns:** *Resident* V had a spinal tumor resulting in paralysis of *their* lower extremities. The physical therapist assistant provides verbal instruction for *Resident* V to navigate *their* manual wheelchair in *their* room and into the hallway while making two turns.

   Coding: GG0170R would be coded 04, Supervision or touching assistance.
   Rationale: The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

6. **Indicate the type of wheelchair/scooter used:** In the above example *Resident* V used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: *Resident* V used a manual wheelchair during the assessment period.

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, *Resident* R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into *their* room and then turning into *their* bathroom.

   Coding: GG0170R would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort to assist the resident to complete the activity.

8. **Indicate the type of wheelchair/scooter used:** In the above example *Resident* R used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: *Resident* R used a manual wheelchair during the assessment period.

Examples for GG0170S, Wheel 150 feet and GG0170SS, Indicate the type of wheelchair/scooter used

1. **Wheel 150 feet:** *Resident* G always uses a motorized scooter to mobilize *them*self down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

2. **Indicate the type of wheelchair/scooter used:** In the example above, *Resident* G uses a motorized scooter.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: *Resident* G used a motorized scooter during the assessment period.

Draft

GG0170: Mobility (cont.)

3. **Wheel 150 feet:** *Resident* N uses a below-the-knee prosthetic limb. *Resident* N has peripheral neuropathy and limited vision due to complications of diabetes. *Resident* N's prior preference was to ambulate within the home and use a manual wheelchair when mobilizing *them*self within the community. *Resident* N is assessed for the activity of 150 feet wheelchair mobility. *Resident* N's usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.

   Coding: GG0170S would be coded 04, Supervision or touching assistance.

   Rationale: *Resident* N requires the helper to provide verbal cues for *their* safety when using a wheelchair for 150 feet.

4. **Indicate the type of wheelchair/scooter used:** In the above example *Resident* N used a manual wheelchair during the assessment period.

   Coding: GG0170SS would be coded 1, Manual.

   Rationale: *Resident* N used a manual wheelchair during the assessment period.

5. **Wheel 150 feet:** *Resident* L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. *Resident* L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. *They* occasionally need reminders to slow down around the turns and require assistance from the nurse for backing up the scooter when barriers are present.

   Coding: GG0170S would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half of the effort to complete the activity of wheel 150 feet.

6. **Indicate the type of wheelchair/scooter used:** *Resident* L used a motorized wheelchair during the assessment period.

   Coding: GG0170SS would be coded 2, Motorized.

   Rationale: *Resident* L used a motorized wheelchair during the assessment period.

7. **Wheel 150 feet:** *Resident* M has had a mild stroke, resulting in muscle weakness in *their* right upper and lower extremities. *Resident* M uses a manual wheelchair. *They* usually can self-propel *them*self about 60 to 70 feet but need assistance from a helper to complete the distance of 150 feet.

   Coding: GG0170S would be coded 02, Substantial/Maximal assistance.

   Rationale: The helper provides more than half of the effort to complete the activity of wheel 150 feet.

8. **Indicate the type of wheelchair/scooter used:** In the above example, *Resident* M used a manual wheelchair during the assessment period.

   Coding: GG0170SS would be coded 1, Manual.

   Rationale: *Resident* M used a manual wheelchair during the assessment period.

Draft

GG0170: Mobility (cont.)

9. **Wheel 150 feet:** *Resident* A has a cardiac condition with medical precautions that do not allow *them* to propel *their* own wheelchair. *Resident* A is completely dependent on a helper to wheel *them* 150 feet using a manual wheelchair.

   Coding: GG0170S would be coded 01, Dependent.
   Rationale: The helper provides all the effort and the resident does none of the effort to complete the activity of wheel 150 feet.

10. **Indicate the type of wheelchair/scooter used:** In the above example, *Resident* A is wheeled using a manual wheelchair during the assessment period.

    Coding: GG0170SS would be coded 1, Manual.
    Rationale: *Resident* A is assisted using a manual wheelchair during the assessment period.

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining a resident's score for sit to lying and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how *Resident* H moves *them*self from sitting on the side of the bed to lying flat on the bed. When *they are* sitting on the side of the bed, how do *they* move to lying on *their* back?"

   Certified nursing assistant: "*They* can lie down with some help."

   Nurse: "Please describe how much help *they* need and exactly how you help *them*."

   Certified nursing assistant: "I have to lift and position *their* right leg, but once I do that, *they* can use *their* arms to position *their* upper body."

   In this example, the nurse inquired specifically about how *Resident* H moves from a sitting position to a lying position. The nurse asked about physical assistance.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant lifts *Resident* H's right leg and helps *them* position it as *they* move from a sitting position to a lying position. The helper does less than half the effort.

GG0170: Mobility (cont.)

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident's score for lying to sitting on side of bed and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how *Resident* L moves *them*self in bed. When *they are* in bed, how do *they* move from lying on *their* back to sitting up on the side of the bed?"

   Certified nursing assistant: "*They* can sit up by *them*self."

   Nurse: "*They* sit up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind *them* to check on the position of *their* arm that has limited movement and sensation as *they* move in the bed, but once I remind *them* to check *their* arm, *they* can do it *them*self."

   In this example, the nurse inquired specifically about how *Resident* L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides verbal instructions as the resident moves from a lying to sitting position.

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident's sit to stand score and a certified nursing assistant regarding the resident's sit to stand ability:

   Nurse: "Please describe how *Resident* L usually moves from sitting on the side of the bed or chair to a standing position. Once *they are* sitting, how do *they* get to a standing position?"

   Certified nursing assistant: "*They* need help to get to sitting up and then standing."

   Nurse: "I'd like to know how much help *they* need for safely rising up from sitting in a chair or sitting on the bed to get to a standing position."

   Certified nursing assistant: "*They* need two people to assist *them* to stand up from sitting on the side of the bed or when *they are* sitting in a chair."

   In this example, the nurse inquired specifically about how *Resident* L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: *Resident* L requires the assistance of two helpers to complete the activity.

Draft

GG0170: Mobility (cont.)

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident's chair/bed-to-chair transfer ability:

   Nurse: "Please describe how *Resident* C moves into the chair from the bed. When *they are* sitting at the side of the bed, how much help do *they* need to move from the bed to the chair?"

   Certified nursing assistant: "*They* need me to help *them* move from the bed to the chair."

   Nurse: "Do *they* help with these transfers when you give *them* any instructions, setup, or physical help?"

   Certified nursing assistant: "Yes, *they* will follow some of my instructions to get ready to transfer, such as moving *their* feet from being spread out to placing them under *their* knees. I have to place the chair close to the bed and then I lift *them* because *they are* very weak. I then tell *them* to reach for the armrest of the chair. *Resident* C follows these directions and that helps a little in transferring *them* from the bed to the chair. *They* do help with the transfer."

   In this example, the nurse inquired specifically about how *Resident* C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* C received.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

Draft

GG0170: Mobility (cont.)

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident's score and a certified nursing assistant regarding a resident's toilet transfer assessment:

   Nurse: "I understand that *Resident* M usually uses a wheelchair to get to *their* toilet. Please describe how *Resident* M moves from *their* wheelchair to the toilet. How do *they* move from sitting in a wheelchair to sitting on the toilet?"

   Certified nursing assistant: "It is hard for *them*, but *they* do it with my help."

   Nurse: "Can you describe the amount of help in more detail?"

   Certified nursing assistant: "I have to give *them* a bit of a lift using a gait belt to get *them* to stand and then remind *them* to reach for the toilet grab bar while *they* pivot to the toilet. Sometimes, I have to remind *them* to take a step while *they* pivot to or from the toilet, but *they* do most of the effort *them*self."

   In this example, the nurse inquired specifically about how *Resident* M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* M received.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for walking 50 feet with two turns and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "How much help does *Resident* T need to walk 50 feet and make two turns once *they are* standing?"

   Certified nursing assistant: "*They* need help to do that."

   Nurse: "How much help do *they* need?"

   Certified nursing assistant: "*They* walk about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case *they* need to sit down."

   In this example, the nurse inquired specifically about how *Resident* T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* T received.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: *Resident* T requires two helpers to complete this activity.

Draft

GG0170: Mobility (cont.)

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident's score for walking 150 feet and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "Please describe how *Resident* D walks 150 feet in the corridor once *they are* standing."

   Certified nursing assistant: "*They* use a walker and some help."

   Nurse: "*They* use a walker and how much instructions or physical help do *they* need?"

   Certified nursing assistant: "I have to support *them* by holding onto the gait belt that is around *their* waist so that *they* don't fall. *They* do push the walker forward most of the time."

   Nurse: "Do you help with more than or less than half the effort?"

   Certified nursing assistant: "I have to hold onto *their* belt firmly when *they* walk because *they* frequently lose *their* balance when taking steps. *Their* balance gets worse the further *they* walk, but *they are* very motivated to keep walking. I would say I help *them* with more than half the effort."

   In this example, the nurse inquired specifically about how *Resident* D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* D received.

   Coding: GG0170K would be coded 02, Substantial/maximal assistance.

   Rationale: The certified nursing assistant provides trunk support that is more than half the effort as *Resident* D walks 150 feet.

Draft

GG0170: Mobility (cont.)

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for wheel 50 feet with two turns and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that *Resident* R uses a manual wheelchair. Describe to me how *Resident* R wheels *them*self 50 feet and makes two turns once *they are* seated in the wheelchair."

   Certified nursing assistant: "*They* wheel *them*self."

   Nurse: "*They* wheel *them*self without any instructions or physical help?"

   Certified nursing assistant: "Well yes, *they* need help to get around turns, so I have to help *them* and set *them* on a straight path, but once I do, *they* wheel *them*self."

   In this example, the nurse inquired specifically about how *Resident* R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* R received.

   Coding: GG0170R would be coded 03, Partial/Moderate assistance.

   Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident's score for wheel 150 feet and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that *Resident* G usually uses an electric scooter for longer distances. Once *they are* seated in the scooter, do *they* need any help to mobilize *them*self at least 150 feet?"

   Certified nursing assistant: "*They* drive the scooter *them*self … *they are* very slow."

   Nurse: "*They* use the scooter *them*self without any instructions or physical help?"

   Certified nursing assistant: "That is correct."

   In this example, the nurse inquired specifically about how *Resident* G uses an electric scooter to mobilize *them*self 150 feet. If this nurse had not asked probing questions, *they* would not have received enough information to make an accurate assessment of the actual assistance *Resident* G received.

   Coding: GG0170S would be coded 06, Independent.

   Rationale: The resident navigates in the corridor for at least 150 feet without assistance.

Draft

GG0170: Mobility (cont.)

Discharge Goals: Coding Tips

Discharge goals are coded with each Admission assessment when A0310B = 01, indicating the start of a PPS stay. Discharge goals are not required with stand-alone OBRA assessments.

- For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. *Identifying multiple goals helps to ensure that the assessment accurately reflects resident status and facilitates person-centered individualized care planning.* Use of "activity not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). The use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.
- Licensed qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the resident's prior medical condition, *a*dmission assessment self-care and mobility status, discussions with the resident and family, professional judgment, practice standards, expected treatments, resident motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.
- If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns, during the Admission assessment, a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.

Draft

SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.

H0100: Appliances

H0100. Appliances	
↓ Check all that apply	
☐	A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
☐	B. **External catheter**
☐	C. **Ostomy** (including urostomy, ileostomy, and colostomy)
☐	D. **Intermittent catheterization**
☐	Z. **None of the above**

Item Rationale

Health-related Quality of Life

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote resident dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote resident dignity.

Planning for Care

- Care planning should include interventions that are consistent with the resident's goals and minimize complications associated with appliance use.

DEFINITIONS

INDWELLING CATHETER
A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

SUPRAPUBIC CATHETER
An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

NEPHROSTOMY TUBE
A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.

Draft

H0100: Appliances (cont.)

- Care planning should be based on an assessment and evaluation of the resident's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status, catheter status, environmental factors related to continence programs, and the resident's response to catheter/continence services.

Steps for Assessment

1. Examine the resident to note the presence of any urinary or bowel appliances.
2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

*Check next to each appliance that was used at any time in the past 7 days. Select **none of the above** if none of the appliances A-D were used in the past 7 days.*

- **H0100A,** indwelling catheter (including suprapubic catheter and nephrostomy tube)
- **H0100B,** external catheter
- **H0100C,** ostomy (including urostomy, ileostomy, and colostomy)
- **H0100D,** intermittent catheterization
- **H0100Z,** none of the above

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters and external urinary pouches are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterizations for urine specimen *collection or other diagnostic exams (e.g., to measure post-void residual)* during look-back period as intermittent catheterization.

DEFINITIONS

EXTERNAL CATHETER
Device attached to the shaft of the penis like a condom or a receptacle pouch that fits around the labia majora and connected to a drainage bag.

OSTOMY
Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

UROSTOMY
A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

ILEOSTOMY
A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

COLOSTOMY
A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

INTERMITTENT CATHETERIZATION
Insertion and removal of a catheter through the urethra for bladder drainage.

Draft

H0100: Appliances (cont.)

- Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

H0200: Urinary Toileting Program

H0200. Urinary Toileting Program	
Enter Code ☐	**A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? 0. **No** → Skip to H0300, Urinary Continence 1. **Yes** → Continue to H0200B, Response 9. **Unable to determine** → Skip to H0200C, Current toileting program or trial
Enter Code ☐	**B. Response -** What was the resident's response to the trial program? 0. **No improvement** 1. **Decreased wetness** 2. **Completely dry** (continent) 9. **Unable to determine** or trial in progress
Enter Code ☐	**C. Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are
  - determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
  - completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and
  - implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of residents will have a decrease or resolution of incontinence in response to a toileting program.
- If incontinence is not decreased or resolved with a toileting trial, consider whether other reversible or treatable causes are present.

Draft

H0200: Urinary Toileting Program (cont.)

- Residents may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.
- Residents who do not respond to a toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as checking the resident for incontinence and changing *their* brief if needed and providing good skin care).

Steps for Assessment: H0200A, Trial of a Toileting Program

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

1. Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial should include observations of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary. Toileting programs may have different names, e.g., habit training/scheduled voiding, bladder rehabilitation/bladder retraining.
2. Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence.
3. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of episodes.
4. Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program.
5. Residents should be reevaluated whenever there is a change in cognition, physical ability, or urinary tract function. Nursing home staff must use clinical judgment to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trial or, if the toileting trial was unsuccessful, the need for a trial of a different toileting program.

DEFINITIONS

BLADDER REHABILITATION/ BLADDER RETRAINING
A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

PROMPTED VOIDING
Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) using a schedule and prompting the resident to toilet, and (3) praise and positive feedback when the resident is continent and attempts to toilet.

HABIT TRAINING/ SCHEDULED VOIDING
A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.

CHECK AND CHANGE
Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200B, Response to Trial Toileting Program

1. Review the resident's responses as recorded during the toileting trial, noting any change in the number of incontinence episodes or degree of wetness the resident experiences.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern;
   - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.
3. Guidance for developing a toileting program may be obtained from sources found in Appendix C.

Coding Instructions H0200A, Toileting Program Trial

- **Code 0, no:** if for any reason the resident did not undergo a toileting trial. This includes residents who are continent of urine with or without toileting assistance, or who use a permanent catheter or ostomy, as well as residents who prefer not to participate in a trial. Skip to **Urinary Continence** item (H0300).
- **Code 1, yes:** for residents who underwent a trial of an individualized, resident-centered toileting program at least once since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.
- **Code 9, unable to determine:** if records cannot be obtained to determine if a trial toileting program has been attempted. If code 9, skip H0200B and go to H0200C, **Current Toileting Program or Trial**.

Coding Instructions H0200B, Toileting Program Trial Response

- **Code 0, no improvement:** if the frequency of resident's urinary incontinence did not decrease during the toileting trial.
- **Code 1, decreased wetness:** if the resident's urinary incontinence frequency decreased, but the resident remained incontinent. There is no quantitative definition of improvement. However, the improvement should be clinically meaningful—for example, having at least one less incontinent void per day than before the toileting program was implemented.

DRAFT

H0200: Urinary Toileting Program (cont.)

- **Code 2, completely dry (continent):** if the resident becomes completely continent of urine, with no episodes of urinary incontinence during the toileting trial. (For residents who have undergone more than one toileting program trial during their stay, use the most recent trial to complete this item.)
- **Code 9, unable to determine or trial in progress:** if the response to the toileting trial cannot be determined because information cannot be found or because the trial is still in progress.

Coding Instructions H0200C, Current Toileting Program

- **Code 0, no:** if an individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence.
- **Code 1, yes:** for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200A-C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to
  - simply tracking continence status,
  - changing pads or wet garments, and
  - random assistance with toileting or hygiene.
- For a resident currently undergoing a trial of a toileting program,
  - H0200A would be **coded 1, yes,**
  - H0200B would be **coded 9, unable to determine or trial in progress**, and
  - H0200C would be **coded 1, yes.**

Draft

H0200: Urinary Toileting Program (cont.)

Examples

1. *Resident* H has a diagnosis of advanced Alzheimer's disease. *They are* dependent on the staff for *their* ADLs, do not have the cognitive ability to void in the toilet or other appropriate receptacle, and *are* totally incontinent. *Their* voiding assessment/diary indicates no pattern to *their* incontinence. *Their* care plan states that due to *their* total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb *their* sleep.

   Coding: H0200A would be **coded as 0, no**. H0200B and H0200C would be skipped.

   Rationale: Based on this resident's voiding assessment/diary, there was no pattern to *their* incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no, skip to H0300, Urinary Continence.

2. *Resident* M., who has a diagnosis of congestive heart failure (CHF) and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed *them* for a reversible cause of the incontinence and has evaluated *their* voiding pattern using a voiding assessment/diary. After completing the assessment, it was determined that incontinence episodes could be reduced. A plan was developed and implemented that called for toileting every hour for 4 hours after receiving *their* 8 a.m. diuretic, then every 3 hours until bedtime at 9 p.m. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will reevaluate the resident's response to the plan after 1 month and adjust as needed.

   Coding: H0200A would be **coded as 1, yes.**

   H0200B would be **coded as 9, unable to determine or trial in progress.**

   H0200C would be **coded as 1, current toileting program or trial.**

   Rationale: Based on this resident's voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as 1, yes. Based on the assessment it was determined that incontinence episodes could be reduced, therefore H0200B is coded as 9, unable to determine or trial in progress. An individualized plan has been developed, implemented, and communicated to the resident and staff, therefore H0200C is coded as 1, current toileting program or trial.

Draft

H0300: Urinary Continence

H0300. Urinary Continence	
Enter Code ☐	**Urinary continence -** Select the one category that best describes the resident 0. **Always continent** 1. **Occasionally incontinent** (less than 7 episodes of incontinence) 2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. **Always incontinent** (no episodes of continent voiding) 9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - — interfere with participation in activities,
  - — be socially embarrassing and lead to increased feelings of dependency,
  - — increase risk of long-term institutionalization,
  - — increase risk of skin rashes and breakdown,
  - — increase risk of repeated urinary tract infections, and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

DEFINITIONS

URINARY INCONTINENCE
The involuntary loss of urine.

CONTINENCE
Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
  - — bladder retraining, prompted voiding, or scheduled toileting.
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the resident if *they are* capable of reliably reporting *their* continence. Speak with family members or significant others if the resident is not able to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Draft

H0300: Urinary Continence (cont.)

Coding Instructions

- **Code 0, always continent:** if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
- **Code 3, always incontinent:** if during the 7-day look-back period, the resident had no continent voids.
- **Code 9, not rated:** if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

Examples

1. An 86-year-old resident has had longstanding stress-type incontinence for many years. When *they have* an upper respiratory infection and *are* coughing, *they* involuntarily lose urine. However, during the current 7-day look-back period, the resident has been free of respiratory symptoms and has not had an episode of incontinence.

   Coding: H0300 would be **coded 0, always continent**.
   Rationale: Even though the resident has known intermittent stress incontinence, *they were* continent during the current 7-day look-back period.

> ***DEFINITION***
>
> ***STRESS INCONTINENCE***
> *Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.*

2. A resident with multi-infarct dementia is incontinent of urine on three occasions on day one of observation, continent of urine in response to toileting on days two and three, and has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

   Coding: H0300 would be **coded as 2, frequently incontinent.**
   Rationale: The resident had seven documented episodes of urinary incontinence *during* the look-back period. The criterion for "frequent" incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

Draft

H0300: Urinary Continence (cont.)

3. A resident with Parkinson's disease is severely immobile and cannot be transferred to a toilet. *They are* unable to use a urinal, and *the incontinence* is managed by *the resident using* adult briefs and bed pads that are regularly changed. *They* did not have a continent void during the 7-day look-back period.

   Coding: H0300 would be **coded as 3, always incontinent.**

   Rationale: The resident has no urinary continent episodes and cannot be toileted due to severe disability or discomfort. Incontinence is managed by a "check and change" protocol.

4. A resident had one continent urinary void during the 7-day look-back period, after the nursing assistant assisted *them* to the toilet and helped with clothing. All other voids were incontinent.

   Coding: H0300 would be **coded as 2, frequently incontinent.**

   Rationale: The resident had at least one continent void during the look-back period. The reason for the continence does not enter into the coding decision.

H0400: Bowel Continence

H0400. Bowel Continence	
Enter Code ☐	**Bowel continence -** Select the one category that best describes the resident 0. **Always continent** 1. **Occasionally incontinent** (one episode of bowel incontinence) 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. **Always incontinent** (no episodes of continent bowel movements) 9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - interfere with participation in activities,
  - be socially embarrassing and lead to increased feelings of dependency,
  - increase risk of long-term institutionalization,
  - increase risk of skin rashes and breakdown, and
  - increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
  - eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.

Draft

H0400: Bowel Continence (cont.)

- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination.
2. Interview the resident if *they are* capable of reliably reporting *their* bowel habits. Speak with family members or significant other if the resident is unable to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- **Code 3, always incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.
- **Code 9, not rated:** if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation.)

Coding Tips and Special Populations

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Draft

H0500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code ☐	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences *associated with* incontinence.
- Many incontinent residents respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Residents who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as a regular check and change program with good skin care).
- Residents with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
   - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.

Draft

H0500: Bowel Toileting Program (cont.)

Coding Instructions

- **Code 0, no:** if the resident is not currently on a toileting program targeted specifically at managing bowel continence.
- **Code 1, yes:** if the resident is currently on a toileting program targeted specifically at managing bowel continence.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code ☐	Constipation present? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as
  - dehydration due to a medical condition or inadequate access to and intake of fluid, and
  - side effects of medications.

DEFINITION

CONSTIPATION
If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, physician history and physical examination to determine if the resident has had problems with constipation during the 7-day look-back period.
2. Residents who are capable of reliably reporting their continence and bowel habits should be interviewed. Speak with family members or significant others if the resident is unable to report on bowel habits.
3. Ask direct care staff who routinely work with the resident on all shifts about problems with constipation.

DEFINITION

FECAL IMPACTION
A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.

Draft

H0600: Bowel Patterns (cont.)

Coding Instructions

- **Code 0, no:** if the resident shows no signs of constipation during the look-back period.
- **Code 1, yes:** if the resident shows signs of constipation during the look-back period.

Coding Tips and Special Populations

- Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

Draft