SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior functioning admission performance, discharge goals and discharge performance. 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 patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.	
3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. **2. Needed Some Help** - Patient needed partial assistance from another person to complete activities. **1. Dependent** - A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	↓ **Enter Codes In Boxes** ☐ **B. Indoor Mobility (Ambulation):** Code the patient'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.

Item Rationale

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

Steps for Assessment

- Interview patient or family or review patient's medical records describing patient's prior functioning with everyday activities.

Coding Instructions

Complete only if A0250 = 01 Admission.

- Code 3, Independent, if the patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- Code 2, Needed Some Help, if the patient needed partial assistance from another person to complete activities.
- Code 1, Dependent, if the helper completed the activities for the patient.
- Code 8, Unknown, if the patient's usual ability prior to the current illness, exacerbation, or injury is unknown.
- Code 9, Not Applicable, if the activity was not applicable to the patient prior to the current illness, exacerbation, or injury.

Coding Tips

- Record the patient's usual ability to perform indoor mobility (ambulation) prior to the current illness, exacerbation, or injury.
- If no information about the patient's ability is available after attempts to interview patient or family and after reviewing patient's medical record, code 8. Unknown.
- If the clinician does not attempt to gather this information, he or she should enter a dash ("-") for this item. An example of appropriate use of a dash is if a patient is admitted to and discharged from the LTCH before the facility has completed the patient/family interview and no medical records are available for the clinician to review.

Examples for Coding Prior Functioning: Everyday Activities

1. Indoor Mobility (Ambulation): Mrs. G had a stroke one year ago and has now experienced a second stroke. She needs assistance to complete many everyday activities. She did not walk immediately prior to the second stroke as a result of her first stroke.

   Coding: GG0100B, would be coded as 9, Not Applicable.

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

2. Indoor Mobility (Ambulation): Mr. C was admitted to an LTCH after experiencing a stroke. Prior to the stroke, he used a cane to walk from room to room. In the morning, Mr. C's wife would provide steadying assistance to Mr. C when he walked from room to room due to joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day upon walking from room to room.

   Coding: GG0100B. Prior Functioning - Indoor Mobility (Ambulation) would be coded as 2, Needed Some Help.

   Rationale: The patient needed some assistance (steadying assistance) from his wife to complete the activity of walking in the home immediately prior to his stroke.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ **Check all that apply**	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair or scooter**
☐	**C. Mechanical lift**
☐	**Z. None of the above**

Item Rationale

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

Steps for Assessment

- Interview patient or family or review the patient's medical record describing the patient's use of prior devices and aids.

Coding Instructions

Complete only if A0250 = 01 Admission.

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

Example for Coding Prior Device Use

1. Mrs. G has a diagnosis of tetraplegia complete. She is unable to walk and did not walk prior to the current episode of care that started due to a pressure ulcer and respiratory infection. She uses a motorized wheelchair to mobilize.

   Coding: GG0110B, Motorized wheelchair or scooter would be checked.
   Rationale: Mrs. G used a motorized wheelchair prior to the current illness/injury.

GG0130. Self-Care (3-day assessment period)

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient'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** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient 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. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable**
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 to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.	☐☐	☐☐
B. **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]	☐☐	☐☐
C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.	☐☐	☐☐
D. **Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.	☐☐	☐☐

Item Rationale

- Patients in LTCHs may have self-care limitations on admission. In addition, patients may be at risk of further functional decline during their stay in the LTCH.

Steps for Assessment

1. Assess the patient's self-care status based on direct observation, the patient's self-report, family reports, and direct care staff reports documented in the patient's medical record during the 3-day assessment period.
2. Patients should be allowed to perform activities as independently as possible, as long as they are safe.
3. If helper assistance is required because patient's performance is unsafe or of poor quality, score 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. If the patient's self-care performance varies during the assessment period, report the patient's usual status, **not** the patient's most independent performance and **not** the patient's most dependent episode.
6. Refer to facility, Federal, and State policies and procedures to determine which LTCH staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements.

Assessment Period: The 3-day assessment period for the admission assessment includes the day of admission and the two days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the start of therapy services in order to capture the patient's true admission baseline status. This is because therapy interventions can affect the patent's functional status; the score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the two calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.

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

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.

- Code 06, Independent, if the patient completes the activity by him/herself with no assistance from a helper.

- Code 05, Setup or clean-up assistance, if the helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient requires assistance cutting up food or opening container, or requires set-up of hygiene item(s) or assistive device(s).
- Code 04, Supervision or touching assistance, if the helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete activity; or patient may require only incidental help such as contact guard or steadying assist 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.
- 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. Patient does none of the effort to complete the activity; or the assistance of two or more helpers is required for the patient to complete the activity.
- Code 07, Patient refused, if the patient refused to complete the activity.
- Code 09, Not Applicable, if the patient did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns, if the activity was not attempted due to medical condition or safety concerns.

Coding Tips

General coding tips:

- When reviewing the medical record, interviewing staff, and observing the patient, be familiar with the definition for each activity. For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and liquid to the mouth and swallow food once the meal is presented on a table/tray.
- If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if the patient refused to attempt the activity, code 09 if the activity is not applicable for the patient, or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.

- To clarify your own understanding of the patient's performance of an activity, ask probing questions to staff about the patient, beginning with the general and proceeding to the more specific. See examples of using probes when talking to staff, at the end of this section.
- A *dash* ("-") sign indicates *"No information."* CMS expects dash use for quality indicator items to be a rare occurrence. Use of dashes for quality items may result in a payment reduction. Do not use a dash ("-") if the reason that the item was not assessed because the patient refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88). A dash may be used for GG0130 discharge goal items provided that at least one self-care or one mobility item has a discharge goal.
- The self-care items are not included on the Unplanned Discharge Assessment or the Expired Assessment.
- 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 patient'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.

Coding tips for coding the patient's usual status:

- On the admission assessment, code the patient's usual performance using the 6-point scale, or code the reason an activity was not attempted, as well as the patient's discharge goal(s) using the 6-point scale. Instructions about coding discharge goals are provided below.
- On the discharge assessment, code the patient's usual performance using the 6-point scale or code the reason an activity was not attempted.
- Record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance during the assessment period.
- Direct observation of the patient's performance, reviews of medical records and interviews of clinical staff are methods of gathering information to determine the patient's usual performance.
- Do not record the staff's assessment of the patient's potential capability to perform the activity.

Coding tips for patients with incomplete stays:

- For patients with incomplete stays, such as a patient with an emergency discharge, the self-care and mobility items may be coded as 88, Not attempted due to medical condition or safety concerns. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting (short-stay acute care hospital, critical access hospital, inpatient psychiatric facility, because of a medical emergency); patients discharged to a

hospice; patients discharged to another LTCH; patients who die or leave the LTCH against medical advice; and patients with a length of stay of less than 3 days.

Examples for Coding Admission Performance or Discharge Performance

1. **Eating:** Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. After eating three-fourths of her meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

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

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

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

3. **Eating:** Mr. A. eats meals without any physical assistance or supervision from a helper. He has a gastrostomy tube (G-tube), but it is no longer used, and it will be removed later today.

   Coding: GG0130A. Eating would be coded 06, Independent.
   Rationale: The patient can independently complete the activity without any assistance from a helper for this activity. The presence of a G-tube does not affect the eating score.

4. **Eating:** The nurse opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

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

5. **Eating:** Mrs. H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues to use the compensatory strategy of extra swallows to clear the food.

   Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.

Rationale: Mrs. H swallows all types of food consistencies, and requires verbal cueing (supervision) from the helper. Code based on assistance from the helper. The coding is not based on whether or not the patient had restrictions related to food consistency.

6. **Eating:** Mrs. V has had difficulty seeing on her left side since her stroke. During meals, a helper has to remind her to scan her entire meal tray to ensure she has seen all the food.

   Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cuing assistance as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

7. **Eating:** Mrs. N is impulsive. While she eats, a helper provides verbal and tactile cuing so that Mrs. N does not lift her fork to her mouth until she has swallowed the food in her mouth.

   Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.
   Rationale: The patient requires supervision and touching assistance to eat safely.

8. **Eating:** Mr. R is unable to eat or drink by mouth since he had a stroke one week ago. He receives nutrition and hydration through a gastrostomy tube (G-tube), which is administered by nurses.

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

9. **Eating:** Mr. F is fed by the certified nursing assistant, because Mr. F has severe arm weakness, and he is unable to assist.

   Coding: GG0130A. Eating would be coded 01, Dependent
   Rationale: The helper does all of the effort. The patient does not contribute any effort to complete the activity.

10. **Oral Hygiene:** Mrs. F brushes her teeth while sitting on the side of the bed. The certified nursing assistant gathers her toothbrush, toothpaste, water and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

    Coding: GG0130B. Oral hygiene would be coded 05. Setup or clean-up assistance.
    Rationale: The helper provides setup and clean-up assistance. The patient brushes her teeth without any help.

11. **Oral Hygiene:** The nurse provides steadying assistance to Mr. S as he walks to the bathroom. The nurse applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the nurse returns provides steadying assistance as the patient walks back to his bed.

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

12. **Oral hygiene:** The certified nursing assistant provides Mrs. K water and toothpaste to clean her dentures. Mrs. K cleans her upper denture plate. Mrs. K then cleans half of her lower denture plate, but states she is tired and unable to finish cleaning her lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Mrs. K replaces the dentures in her mouth.

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

13. **Oral Hygiene:** Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The helper completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

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

14. **Oral Hygiene:** Mr. G has Parkinson's disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts tooth brushing and the certified nursing assistant usually completes the activity by performing more than half of this activity.

    Coding: GG0130B. Oral Hygiene would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provided more than half the effort for the patient to complete the activity of oral hygiene.

15. **Oral Hygiene:** Ms. T has Lewy body dementia and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

    Coding: GG0130B. Oral Hygiene would be coded 01, Dependent.
    Rationale: The helper provides all the effort for the activity to be completed.

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

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

17. **Toileting hygiene:** Mrs. L uses the toilet to void and have bowel movements. Mrs. L is unsteady, so the certified nursing assistant walks into the bathroom with her in case she needs help. During the assessment period, a staff member has been present in the bathroom, but has not needed to provide any physical assistance with managing clothes or cleansing.

    Coding: GG0130C. Toileting hygiene would be coded 04, Supervision or touching assistance.
    Rationale: The helper provides supervision as the patient performs the toilet hygiene activity. The patient is unsteady and the staff provide supervision for safety reasons.

18. **Toileting hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself and pulls her underwear back up.

    Coding**:** GG0130C. Toileting hygiene would be coded 03, Partial/moderate assistance
    Rationale**:** The patient performs more than half the effort; the helper does less than half the effort. The patient does 2 of the 3 toileting hygiene tasks.

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

    Coding: GG0130C. Toileting hygiene would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provided more than half the effort for the patient to complete the activity of toileting hygiene.

20. **Toileting hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bed pan when voiding or having bowel movements and requires two certified

nursing assistants to mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene.

Coding: GG0130C. Toileting hygiene would be coded 01, Dependent.

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

21. **Wash upper body:** After the helper places the wash basin filled with water, soap, and a towel on the bedside table, the helper leaves the room. Mrs. L washes, rinses, and dries her upper body. The helper returns and removes all of the items once Mrs. L is done.

    Coding: GG0130D. Wash upper body would be coded 05, Setup or clean-up assistance.

    Rationale: The helper provides setup and cleanup assistance. Assistance with washing, rinsing, and drying the back is not considered when coding this item.

22. **Wash upper body:** Mr. C is sitting in his bed where the certified nursing assistant provides him with a washcloth and then opens the soap container to enable Mr. C to wash his face, hands, chest, and arms. Due to arthritis, Mr. C is unable to manage fine motor tasks such as container management. Mr. C then completes the activity safely without verbal or physical assistance or supervision.

    Coding: GG0130D. Wash upper body would be coded 05, Setup or clean-up assistance.

    Rationale: The helper provided setup only prior to the activity.

23. **Wash upper body:** Mrs. L has severe rheumatoid arthritis and peripheral vascular disease that affects her hands with joint pain, weakness, numbness, and tingling. Mrs. L uses a wash mitt to wash her upper arms and part of her chest. The certified nursing assistant helps to wash and rinse her face and part of her chest. Mrs. L rinses her arms and chest after the certified nursing assistant places a rinsed mitt on her hand. She soaks her hands in soapy water and rinses them under the faucet that is set up for her use. Mrs. L slowly wipes herself with a towel.

    Coding: GG0130D. Wash upper body would be coded 03, Partial/moderate assistance.

    Rationale: The helper provided less than half the effort for the patient to complete the activity of wash upper body.

24. **Wash upper body:** Mr. D has amyotrophic lateral sclerosis and has upper extremity weakness and uncontrollable twitching. Mr. D is very motivated to perform the activity of washing his upper body. The nurse always offers to work with Mr. T hand-over-hand for the activity to manage his twitching while he washes, rinses and dries his face, hands, arms, and chest. Mr. D requires the nurse to move his hands and contain his tremors during this activity, thus the majority (more than half) of the activity effort is performed by the nurse.

    Coding: GG0130D. Wash upper body would be coded 02, Substantial/maximal assistance.

    Rationale: The helper provided more than half the effort for the patient to complete the activity of wash upper body.

25. **Wash upper body:** Mr. W is unable to sit on the side of the bed or assist with washing his upper body due to severe weakness. The certified nursing assistant raises the head of the bed and washes Mr. W's face, hands, chest, and arms.

    Coding: GG0130D. Wash upper body would be coded 01, Dependent.

    Rationale: The helper completes the activity. The patient does not assist with washing of the upper body.

Examples of Conversations with Staff

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

   Nurse: "Please describe to me how Mr. S eats his meals. Once the food and liquid is presented to him, does he use utensils to bring food to his mouth and swallow?"

   Certified nursing assistant: "No I have to feed him."

   Nurse: "Do you always have to physically feed him or can he sometimes do some aspect of the eating activity with encouragement or cues to feed himself?"

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

   In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she may not have received enough information to make an accurate assessment of the assistance Mr. 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. Eating would be coded 01, Dependent.

   Rationale: The patient requires complete assistance to eat his meals.

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

   Nurse: "Does Mrs. K help with brushing her teeth?"

   Certified nursing assistant: "She can help clean her teeth."

   Nurse: "How much help does she need to brush her teeth?"

   Certified nursing assistant: "She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth."

   In this example, the nurse inquired specifically how Mrs. K manages her oral hygiene. The nurse asked about physical assistance and how the patient performed the activity. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

Coding: GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.

Rationale: The certified nursing assistant provides more than half the effort to complete Mrs. K's oral hygiene.

3. **Toileting hygiene:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the patient's toileting hygiene routine:

   Nurse: "I understand Mrs. J wears a hospital gown and underwear. Describe to me how Mrs. J usually does her toileting hygiene. Is she able to manage her clothing before and after going to the bathroom and is she able to wipe herself?"

   Certified nursing assistant: "She needs help getting to the bathroom and some help to wipe herself."

   Nurse: "She needs assistance to complete her perineal hygiene. Does she manage her underwear before and after using the toilet without you giving her physical assistance, cues or setting her up with the toilet paper?"

   Certified nursing assistant: "No, I have to physically hold onto her gait belt and support her as I pull her underwear down. She wipes her perineal area and then I pull up her underwear afterwards. "

   In this example, the nurse inquired specifically about the three tasks of this activity Mrs. J was able to participate in to manage her toileting hygiene. The nurse asked about instructions and physical assistance.

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

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

4. **Wash upper body:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the patient's washing upper body routine:

   Nurse: "Describe how Mr. C usually washes his upper body. Specifically, does he wash, rinse, and dry his face, hands, chest, and arms while sitting in a chair or bed?"

   Certified nursing assistant: "He has to sit in his bed because he's too weak in the morning to get to the sink, and I have to help him do most of it."

   Nurse: "What can Mr. C complete for himself when washing, rinsing, and drying his upper body? Does he need instructions, safety reminders, setup, or physical help?"

   Certified nursing assistant: "I have to give him a basin of water, washcloth, and open his soap container, lather his wash rag and place it in his hand. I encourage him to wash his arms, but he always gets tired after washing one of his arms. I then do all the remaining washing, rinsing and drying of his upper body. I've tried giving him a little rest break before asking him to continue washing himself, but he then complains of feeling cold and wants me to finish washing him. After washing his upper body, I have to clean up the wash basin, washcloth, and soap for him."

In this example, the nurse inquired specifically how Mr. C washes his upper body. The nurse specifically asked about instructions, safety reminders and physical assistance.

Coding: GG0130D. Wash upper body would be coded 02, Substantial/maximal assistance.

Rationale: The helper provided more than half the effort for the patient to complete the activity of wash upper body.

Discharge Goal: Coding Tips

- Use the 6-point scale to code the patient's discharge goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code discharge goal(s). Use a dash (-) to indicate that a specific activity is not a goal. Of note, one goal must be indicated for either self-care or mobility. **Using the dash in this allowed instance does not affect APU determination**.
- Licensed clinicians can establish a patient's discharge goal(s) at the time of admission based on the patient's prior medical condition, admission assessment self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient'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 submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.
- For the quality measures Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), and the cross-setting quality measure Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), a minimum of one function goal must be coded.

Discharge Goal Coding Examples

Example 1: Discharge Goal Code Is *Higher* than Admission Performance Code

If the clinician determines that the patient is expected to make *gains* in function by discharge, the code reported for discharge goal will be higher than the admission performance code.

Wash Upper Body Admission Performance: Mr. M has stated that he prefers to wash himself rather than depending on helpers or his wife to perform this activity. The clinician assesses Mr. M's admission performance for Wash Upper Body. The clinician codes Mr. M's Admission Performance as 02, Substantial/maximal assistance, because the helper performs more than half the effort.

Wash Upper Body Discharge Goal: The clinician reflects upon the patient's prior self-care functioning, current multiple diagnoses, expected treatments, motivation to improve,

anticipated length of stay, and medical prognosis. The clinician discusses discharge goals with the patient and family and they anticipate that by discharge Mr. M will require a helper to do less than half the effort in assisting him to complete the activity of upper body washing. The clinician codes the Discharge Goal as 03, Partial/moderate assistance.

Example 2: Discharge Goal Code Is the *Same* as Admission Performance Code

The clinician determines that a medically complex patient is not expected to progress to a higher level of functioning during the LTCH stay; however, the clinician determines that the patient would be able to maintain his/her admission functional performance level. The clinician discusses functional status goals with the patient and his 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 patient's admission performance code.

Oral Hygiene Admission Performance and Discharge Goal: In this example, the clinician anticipates that the patient will have the same level of function for oral hygiene at admission and discharge. The patient's admission performance code is coded and the discharge goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. 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, tremors). The clinician observes Mrs. E's admission performance and discusses her usual performance with 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 Mrs. E's limb). The clinician codes Mrs. E's admission performance as 02, Substantial/maximal assistance. The helper does more than half the effort of the activity and performs more than half the effort when lifting or holding her limb also.

Oral Hygiene Admission Performance and Discharge Goal: The clinician anticipates her discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's progressive and degenerative condition, the clinician and patient feel that, while Mrs. E is not expected to make gains in oral hygiene performance, maintaining her function at this same level is desirable and achievable as a discharge goal.

Example 3: Discharge Goal Code Is *Lower* than Admission Performance Code

The clinician determines that a patient 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 patient's admission performance code.

Toileting Hygiene: Mrs. T's participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The patient's discharge *goal* code will be lower than the *admission performance* code.

Toileting Hygiene Admission Performance: Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode for as long as possible rather than using incontinence undergarments. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal

area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The clinician codes the admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. K's toileting hygiene.

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

GG0170: Mobility (3-day assessment period)

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient'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** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient 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. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable**
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.	☐☐	☐☐
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 safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	☐☐	☐☐
D. **Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.	☐☐	☐☐
E. **Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).	☐☐	☐☐
F. **Toilet transfer:** The ability to safely get on and off a toilet or commode.	☐☐	☐☐
H1. Does the patient walk? **0. No,** and walking goal **is not** clinically indicated → *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?* **1. No,** and walking goal **is** clinically indicated → *Code the patient's Discharge Goal(s) for items GG0170I, J, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?* **2. Yes** → *Continue to GG0170I. Walk 10 feet*		☐
I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	☐☐	☐☐
J. **Walk 50 feet with two turns:** Once standing, the ability to walk 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.	☐☐	☐☐
Q1. Does the patient use a wheelchair/scooter? **0. No** → *Skip to H0350. Bladder Continence* **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/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/scooter used. **1. Manual** **2. Motorized**		☐

Item Rationale

- Patients in LTCHs may have mobility limitations on admission. In addition, patients may be at risk of further functional decline during their stay in the LTCH.

Steps for Assessment

1. Assess the patient's mobility abilities based on direct observation, the patient's self-report, and reports from the clinician, care staff, or family as documented in the medical record during the 3-day assessment period.
2. Patients should be allowed to perform activities as independently as possible, as long as they are safe.
3. If helper assistance is required because the patient's performance is unsafe or of poor quality, score 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. If the patient's mobility performance varies during the assessment period, report the patient's usual status, **not** the patient's most independent performance and **not** the patient's most dependent episode.
6. Refer to facility, Federal, and State policies and procedures to determine which LTCH staff members may complete an assessment. Patient assessments are to be done in compliance with facility, Federal, and State requirements.

Assessment Period: The 3-day assessment period for the admission assessment includes the day of admission and the two days following the day of admission, ending at 11:59 pm. Clinicians should code the patient's admission functional status, based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the start of therapy services in order to capture the patient's true admission baseline status. This is because therapy interventions can affect the patent's functional status; the score should reflect the patient's status prior to any benefit from therapy. The discharge assessment period includes the day of discharge and the two calendar days prior to the day of discharge. Code the patient's discharge functional status based on a functional assessment that occurs close to the time of discharge.

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

Turns: The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 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, wheelchair).

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.

- Code 06, Independent, if the patient completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance, if the helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient requires placement of a bed rail to facilitate rolling, or requires set-up of a leg lifter or other assistive devices.
- Code 04, Supervision or touching assistance, if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or patient 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 patient requires assistance such as partial weight-bearing assistance, but HELPER does 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.
- Code 01, Dependent, if the helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
- Code 07, Patient refused, if the patient refused to complete the activity.
- Code 09, Not Applicable, if the patient did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns, if the activity was not attempted due to medical condition or safety concerns.

Coding Tips

General Coding Tips:

- When reviewing health records, interviewing staff, and observing the patient, be familiar with the definition for each activity. For example, when assessing Roll left and right (item GG0170A), determine the level of assistance required to roll from lying on the back to the left side and right side and then return to lying on the back.

- If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if the patient refused to attempt the activity, code 09 if the activity is not applicable for the patient, or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a patient's performance of an activity, ask clinical staff who work with the patient 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* ("-") sign indicates *"No information."* CMS expects dash use for quality indicator items to be a rare occurrence. Use of dashes for quality items may result in a payment reduction. Do not use a dash ("-") if the reason that the activity was not attempted is that the patient refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88). A dash may be used to for GG0170 discharge goal items provided that at least one self-care or one mobility item has a discharge goal.
- Use the 6-point scale to code the patient's discharge goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code discharge goal(s). Use a dash (-) to indicate that a specific activity is not a goal. Of note, one goal must be indicated for either self-care or mobility. **Using the dash in this allowed instance does not affect APU determination**.

Tips for coding the patient's usual performance:

- On the admission assessment, code the patient's usual performance using the 6-point scale, or code the reason an activity was not attempted, as well as the patient's discharge goal(s) using the 6-point scale. Instructions about coding discharge goals are provided below.
- On discharge, use the same 6-point scale or "activity was not attempted" codes that were used on the admission assessment to identify the patient's usual performance on the discharge assessment.
- Record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance.
- Direct observation of the patient's performance, reviews of medical records and interviews of clinical staff are methods of gathering information to determine the patient's usual performance.
- Do not record the staff's assessment of the patient's potential capability to perform the activity.
- The mobility items are not included on the Unplanned Discharge Assessment or the Expired Assessment.

Coding tips for patients with incomplete stays:

- For patients with incomplete stays, such as a patient with an emergency discharge, the self-care and mobility items may be coded as 88, Not attempted due to medical condition or safety concerns. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting (short-stay acute care hospital, critical access hospital, inpatient psychiatric facility, because of a medical emergency); patients discharged to a hospice; patients discharged to another LTCH; patients who die or leave the LTCH against medical advice; and patients with a length of stay of less than 3 days.

Examples

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

   Coding: GG0170A. Roll left and right would be coded 02, Substantial/maximal assistance.
   Rationale: The nurse provided more than half of the effort for the patient to complete the activity of roll left and right.

2. **Roll left and right:** The physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side. He is then instructs him how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. R completes the activity without physical assistance from a helper.

   Coding: GG0170A. Roll left and right would be coded 04, Supervision or touching assistance.
   Rationale: The physical therapist provides verbal cues (i.e., instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back. The physical therapist does not provide any physical assistance.

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

   Coding: GG0170A. Roll left and right would be coded 01, Dependent.
   Rationale: Two certified nursing assistants were needed to help Mr. Z roll to his left and right side while in bed.

4. **Roll left and right:** Mr. R fell and sustained left shoulder contusions and a fractured left hip, and underwent an open reduction internal fixation of the left hip. The physician's order allows him to roll onto the left hip as tolerated. The certified nursing assistant

facilitates Mr. R rolling onto his right side by instructing him to bend his left leg while rolling to his right side. Mr. R needs physical assistance from the helper to initiate his rolling right due to his left arm weakness when grasping the right bedrail to assist in rolling. Mr. R returns to lying on his back without assistance and uses his right arm to grasp the left bedrail to slowly roll onto his left hip and then return to lying on his back.

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

5. **Sit to lying:** Mrs. 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 her right side. The helper lifts and positions Mrs. H's right leg. Mrs. H uses her arms to position her upper body. Overall, Mrs. H performs more than half of the effort.

   Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Mrs. H's right leg and helps her position it as she moves from a seated to a lying position; Mrs. H does more than half of the effort.

6. **Sit to lying:** Mrs. 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 her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

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

7. **Sit to lying**: Mrs. 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 her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist while asked to perform the incremental steps of the activity.

   Coding: GG0170B. Sit to lying 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 patient to complete an activity, code as 01, Dependent.

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

   Coding**:** GG0170C. Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.

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

9. **Lying to sitting on side of bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the occupational therapist performs more than half of the effort.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 02, Substantial/ maximal assistance.
   Rationale: The helper provides lifting assistance (more than half the effort) as the patient moves from a lying to sitting position.

10. **Lying to sitting on side of bed:** Mr. U is obese and recovering from surgery for spinal stenosis with lower extremity weakness. The certified nursing assistant partially lifts Mr. U's trunk to a fully upright sitting position on the bed and minimally lifts each leg toward the edge of the bed. Mr. U then scoots toward the edge of the bed, placing both feet flat onto the floor. Mr. U completes most of the activity himself.

    Coding: GG0170C. Lying to sitting on side of bed would be coded 03, Partial/ moderate assistance.
    Rationale: The helper provided less than half the effort for the patient to complete the activity of lying to sitting on side of bed.

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

    Coding: GG0170C. Lying to sitting on side of bed would be coded 01, Dependent.
    Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the patient.

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

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

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

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

14. **Sit to stand:** Mr. B has complete tetraplegia and is currently unable to stand when getting out of bed. He transfers from his bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to his medical condition.

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

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

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

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

    Coding: GG0170E. Chair/bed-to-chair transfer would be coded 05, Setup or clean-up Assistance
    Rationale: Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.

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

    Coding: GG0170E. Chair/bed-to-chair transfer would be coded 04, Supervision or touching assistance.
    Rationale: The helper provides touching assistance during the transfers.

18. **Chair/bed-to-chair transfer:** Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. 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 Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

    Coding: GG0170E. Chair/bed-to-chair transfer 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 patient to complete an activity, code as 01, Dependent.

19. **Chair/bed-to-chair transfer:** Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides trunk support. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support. Overall, the therapist provides less than half of the effort.

    Coding: GG0170E. Chair/bed-to-chair transfer would be coded 03, Partial/moderate assistance.
    Rationale: The helper provided less than half of the effort for the patient to complete the activity of chair/bed-to-chair transfer.

20. **Toilet transfer:** The certified nursing assistant moves the wheelchair foot rests up so that Ms. T can transfer onto the toilet by herself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer, she flips the foot rests back down herself.

    Coding: GG0170F. Toilet transfer would be coded 05, Setup or clean-up assistance
    Rationale: The helper provides setup assistance (moving the foot rest out of the way) before Mrs. T can transfer safely onto the toilet.

21. **Toilet transfer:** Mrs. Q transfers onto and off the elevated toilet seat with the certified nursing assistant supervising due to her unsteadiness.

    Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.
    Rationale: The helper provides supervision as the patient transfers onto and off the toilet. The patient may use an assistive device.

22. **Toilet transfer:** Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.

    Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance
    Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

23. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z transfers onto the toilet and lowers her underwear. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.

Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.
Rationale: The helper provides steadying assistance as the patient 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.

24. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer.

    Coding: GG0170F. Toilet transfer would be coded 03, Partial/moderate assistance.
    Rationale: The helper provides less than half the effort to complete the activity.

25. **Toilet transfer:** Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. 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. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to further steady herself. The certified nursing assistant slowly lowers Ms. W onto the bedside commode.

    Coding: GG0170F. Toilet transfer would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provided more than half of the effort for the patient to complete the activity of toilet transfer.

26. **Toilet transfer:** Mr. H has paraplegia incomplete, pneumonia, and COPD. Mr. B prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

    Coding: GG0170F. Toilet transfer would be coded 01, Dependent.
    Rationale: The activity required the assistance of two or more helpers for the patient to complete the activity.

27. **Toilet transfer:** Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder and bowel management.

    Coding: GG0170F. Toilet transfer would be coded 88, Not attempted due to medical condition or safety concerns.
    Rationale: The patient does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

28. **Does the patient walk?** Mr. Z currently does not walk, but a walking goal is clinically indicated.

    Coding: GG0170H1. Does the patient walk? would be coded 1, No, and walking goal is clinically indicated. Discharge goal(s) for items GG0170I. Walk 10 feet, J. Walk 50 feet with two turns, and K. Walk 150 feet may be coded.

Rationale: Patient does not currently walk, so no admission performance code is entered for the walking items. However, a walking goal is clinically indicated and walking goals may be coded.

29. **Does the patient walk?** Ms. Y currently walks with great difficulty due to her progressive neurological disease. It is not expected that Ms. Y will continue to walk. Ms. Y also uses a wheelchair so both GG0170H1. Does the patient walk? and GG0170Q1. Does the patient use a wheelchair/scooter? will be coded Yes.

    Coding: GG0170H1. Does the patient walk? would be coded 2, Yes, and each walking admission performance activity for items GG0170I. Walk 10 feet, J. Walk 50 feet with two turns, and K. Walk 150 feet would then be coded.
    Rationale: The patient currently walks and admission performance codes are entered for each walking item.

30. **Walk 10 feet:** Mrs. C has Parkinson's disease and walks with a walker. The physical therapist must advance the walker for Mrs. C with each step. The physical therapist assists Mrs. C by physically initiating the stepping movement forward, advancing Mrs. C's foot during the activity of walking 10 feet. The assistance provided to Mrs. C is more than half of the effort for her to walk the 10 foot distance.

    Coding: GG0170I. Walk 10 feet would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provides more than half the effort as the patient completes the activity.

31. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. The therapy assistant secures Mr. O's arms onto the platform walker's arm supports to reduce the tremors. The therapy assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last 5 feet of the 10-foot walk. Overall, the assistant provides less than half of the effort.

    Coding: GG0170I. Walk 10 feet would be coded 03, Partial/moderate assistance.
    Rationale: The helper provided less than half the effort for the patient to complete the activity walk 10 feet.

32. **Walk 10 feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once the nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker with only touching assistance provided toward the last half of her 10-foot walk.

    Coding: GG0170I. Walk 10 feet would be coded 04, Supervision or touching assistance.
    Rationale: The helper provided touching assistance for the patient to complete the activity of walk 10 feet. Assistance getting from a sitting to standing position is not coded as part of the Walk 10 Feet item.

33. **Walk 50 Feet with Two Turns:** Mr. B is recovering from a stroke and has difficulty walking. He is only able to walk a distance of 30 feet.

    Coding: GG0170J. Walk 50 feet with two turns would be coded 88, Not attempted due to medical condition or safety concerns.
    Rationale: The patient was not able to walk the entire distance, and the patient's ability to walk a shorter distance would be captured in the item "GG0170I Walk 10 feet."

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

    Coding: GG0170J. Walk 50 feet with two turns would be coded 05, Setup or clean-up assistance
    Rationale: Mrs. 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).

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

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

36. **Walk 50 feet with two turns:** Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and making two turns, her husband supports her trunk. He provides less than half the effort.

    Coding: GG0170J. Walk 50 feet with two turns would be coded 03, Partial/moderate assistance.
    Rationale: The helper (her husband) provides trunk support as the patient walks more than 50 feet and two turns (but not 100 feet).

37. **Walk 50 feet with two turns:** Mr. T walks 50 feet with one helper providing trunk support and a second helper providing supervision. Mr. T walks the 50 feet with two turns.

    Coding: GG0170J. Walk 50 feet with two turns would be coded 01, Dependent.
    Rationale: Mr. T requires two helpers to complete the activity.

38. **Walk 50 feet with two turns:** Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides more than half of the effort.

Coding: GG0170J. Walk 50 feet with two turns would be coded 02, Substantial/ maximal assistance.
Rationale: The helper provided more than half of the effort for the patient to complete the activity of walk 50 feet with two turns.

39. **Walk 150 feet:** Mrs. D walks down the hall using her walker and the certified nursing assistant usually needs to provide touching assistance to Mrs. D who intermittently loses her balance while she uses the walker.

    Coding: GG0170K. Walk 150 feet would be coded 04, Supervision or touching assistance.
    Rationale: The helper provides touching assistance intermittently throughout the activity.

40. **Walk 150 feet:** Mr. R has endurance limitations due to heart failure, and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

    Coding: GG0170K. Walk 150 feet would be coded 88, Activity not attempted due to medical or safety concerns.
    Rationale: The activity was not attempted.

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

    Coding: GG0170R. Wheel 50 feet with two turns would be coded 06, Independent.
    Rationale: The patient wheels herself 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.

42. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The therapy assistant is required to walk next to Mr. R. for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The therapy assistant backs up Mr. M's wheelchair for him so that he may continue mobilizing/wheeling himself. Overall, Mr. R provides more than half of the effort.

    Coding: GG0170R. Wheel 50 feet with two turns would be coded 03, Partial/ moderate assistance.
    Rationale: The helper provided less than half of the effort for the patient to complete the activity, wheel 50 feet with two turns. The patient provided more than half the effort.

43. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet then asks the therapist to push the wheelchair an additional 40 feet into her room and her bathroom.

    Coding: GG0170R. Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provides more than half the effort.

44. **Type of wheelchair/scooter used**. Patients may use a manual wheelchair or motorized wheelchair/scooter to accomplish mobilizing different distances. In example 43, Ms. R used a manual wheelchair during the 3-day assessment period.

    Coding: GG0170RR. Indicate the type of wheelchair/scooter used would be coded 1, Manual.
    Rationale: Ms. R used a manual wheelchair scooter during the 3-day assessment period.

45. **Wheel 150 feet**: Mr. G always uses a motorized scooter to mobilize himself down the hallway and the therapist provides cues due to safety issues (to avoid running into the walls).

    Coding: GG0170S. Wheel 150 feet would be coded 04, Supervision or touching assistance.
    Rationale: The helper provides verbal cues to complete the activity.

46. **Type of wheelchair/scooter used.** In example 45, Mr. G always used a motorized scooter to mobilize himself down the hallway and the therapist provides cues due to safety issues (to avoid running into the walls).

    Coding: GG170SS. Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
    Rationale: Mr. G used a motorized scooter during the 3-day assessment period.

47. **Wheel 150 feet:** Mr. L has peripheral neuropathy and limited vision due to complications of diabetes. Mr. L uses a below the knee prosthetic limb. Mr. L's prior preference was to ambulate within the home and use a wheelchair when mobilizing himself while in the community. Mr. L is assessed performing the activity of mobilizing 150 feet in his wheelchair. A helper is needed to provide verbal cues for safety due to vision deficits.

    Coding: GG0170S wheel 150 feet would be coded 04, Supervision or touching assistance.
    Rationale: Mr. L requires the helper to provide verbal cues for his safety when using a wheelchair to mobilize 150 feet.

48. **Wheel 150 feet:** Mr. P has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. P uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized scooter. He occasionally needs

reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.

Coding: GG0170S. Wheel 150 feet 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.

49. **Unplanned discharge:** Mr. C was admitted to the LTCH with healing, complex, post-surgery open reduction internal fixation fractures and sepsis. However, complications during the LTCH stay arise and Mr. C is unexpectedly hospitalized, resulting in his discharge from the LTCH.

    Coding: No function data are reported.
    Rationale: The unplanned discharge assessment form will be completed and no functional status data are reported on this form due to the unexpected discharge.

50. **Unplanned discharge:** Mrs. A. began to show signs and symptoms of a stroke while at the LTCH. Mrs. A. was transferred to an emergency department of an acute hospital in order to diagnose and stabilize her. It was determined that an acute-care admission was required based on the emergency department evaluation of Mrs. A, and she was discharged from the LTCH.

    Coding: No function data are reported.
    Rationale: The unplanned discharge assessment form will be completed and no functional status data are reported on this form due to the unexpected discharge.

51. **Unplanned discharge:** Mr. S was discussing the discharge plans with the LTCH discharge planner and voiced his intent to leave the LTCH despite the physician's recommendation to remain in the LTCH for continued treatment. The nursing staff and physician were made aware of his imminent intent to leave by the LTCH discharge planner. The patient with the assistance of his family promptly left the LTCH, leaving against medical advice. The staff was not able to conduct a discharge assessment for the patient due to his sudden decision to leave the LTCH.

    Coding: No function data are reported.
    Rationale: The unplanned discharge assessment form will be completed and no functional status data are reported on this form due to the unexpected discharge.

52. **Unplanned discharge:** Mr. T voiced his discontent with his physician and the nursing staff at the LTCH facility where he was receiving chemotherapy. The patient refused all alternative treatment options presented and unexpectedly chose to forego all further treatment and return home. The staff was not able to conduct a discharge assessment of the patient due to his sudden decision to leave the LTCH.

    Coding: No function data are reported.

Rationale: The unplanned discharge assessment form will be completed and no functional status data are reported on this form due to the unexpected discharge.

Example of a Probing Conversation with Staff

1. **Roll left and right:** Example of a probing conversation between a nurse determining a patient's score for roll left and right and a certified nursing assistant regarding the patient's bed mobility:

   Nurse: "Describe to me how Mr. R usually moves himself in bed. Once he is in bed, how does he turn from lying on his back to lying on his left and right sides and then return to lying on his back?"

   Certified nursing assistant: "He can roll to his sides by himself."

   Nurse: "He rolls from side to side and returns to lying on his back without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind him to bend his left leg and roll to his right side, and then to roll to his back and then to do the same on his left side and back to his back, but once I remind him he can do it himself."

   In this example, the nurse inquired specifically about how Mr. R moves from lying on his back to lying on his sides and then returns to lying on his back. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. R received.

   Coding: GG0170A. Roll left and right would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides verbal instructions as the patient moves from lying on his back to lying on his sides and then returns to lying on his back.

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

   Nurse: "Please describe how Mrs. H moves herself from sitting on the side of the bed to lying flat on the bed. When she is sitting on the side of the bed, how does she move to lying on her back?"

   Certified nursing assistant: "She can lay down with some help."

   Nurse: "Please describe how much help she needs and how exactly you help her."

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

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

   Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.

Rationale: The certified nursing assistant lifts Mrs. H's right leg and helps her position it as she moves from a sitting position to a lying position. The helper does less than half the effort.

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

   Nurse: "Please describe how Mrs. L moves herself in bed. When she is in bed, how does she move from lying on her back to sitting up on the side of the bed?"

   Certified nursing assistant: "She can sit up by herself."

   Nurse: "She sits up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself."

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

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

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

   Nurse: "Please describe how Mrs. L usually moves from sitting on the side of the bed or chair to a standing position. Once she is sitting, how does she get to a standing position?"

   Certified nursing assistant: "She needs help to get to sitting up and then standing."

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

   Certified nursing assistant: "She needs two people to assist her to stand up from sitting on the side of the bed or when she is sitting in a chair"

   In this example, the nurse inquired specifically about how Mrs. 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. Sit to stand would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

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

Nurse: "Please describe how Mr. C moves into the chair from the bed. When he is sitting at the side of the bed, how much help does he need to move from the bed to the chair?"

Certified nursing assistant: "He needs me to help him move from the bed to the chair."

Nurse: "Does he help with these transfers when you give him any instructions, setup or physical help?"

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

In this example, the nurse inquired specifically about how Mr. C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cuing instructions. If this nurse did not ask probing questions he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. C received.

Coding: GG0170E. Chair/bed-to-chair transfer 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.

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

   Nurse: "I understand that Mrs. M usually uses a wheelchair to get to her toilet. Please describe how Mrs. M moves from her wheelchair to the toilet. How does she move from sitting in a wheelchair to sitting on the toilet?"

   Certified nursing assistant: "It is hard for her, but she does it with my help."

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

   Certified nursing assistant: "I have to give her a bit of a lift using a gait belt to get her to stand and then remind her to reach for the toilet grab bar while she pivots to the toilet. Sometimes, I have to remind her to take a step while she pivots to or from the toilet, but she does most of the effort herself."

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

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

Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

7. **Walk 10 feet:** Example of a probing conversation between a nurse determining a patient's score for walk 10 feet and a certified nursing assistant regarding the patient's walking ability:

   Nurse: "Please describe how Mrs. C usually walks in her room. Once standing, how does she walk 10 feet in her room or the corridor?"

   Certified nursing assistant: "She walks with a walker."

   Nurse: "She walks with a walker without any instructions or physical help?"

   Certified nursing assistant: "No, I have to help her position her walker correctly, remind her to stand up straight so that she is positioned correctly over the walker, and help her intermittently by providing touching assistance and reminding her to advance the walker forward so she doesn't bump into the front of the walker."

   In this example, the nurse inquired specifically about what assistance is needed when Mrs. C walks 10 feet. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. C received.

   Coding: GG0170I. Walk 10 feet would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides cueing, supervision, and touching assistance during the activity.

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

   Nurse: "How much help does Mr. T need to walk 50 feet and make two turns once he is standing?

   Certified nursing assistant: "He needs help to do that."

   Nurse: "How much help does he need?"

   Certified nursing assistant: "He walks about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case he needs to sit down."

   In this example, the nurse inquired specifically about how Mr. T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 01, Dependent.
   Rationale: Mr. T requires two helpers to complete this activity.

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

   Nurse: "Please describe how Mrs. D walks 150 feet in the corridor once she is standing."

   Certified nursing assistant: "She uses a walker and some help."

   Nurse: "She uses a walker and how much instructions or physical help does she need?"

   Certified nursing assistant: "I have to support her by holding onto the gait belt that is around her waist so that she doesn't fall. She does 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 her belt firmly when she walks because she frequently loses her balance when taking steps. Her balance gets worse the further she walks, but she is very motivated to keep walking. I would say I help her with more than half the effort."

   In this example, the nurse inquired specifically about how Mrs. D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

   Coding: GG0170K. Walk 150 feet would be coded 02, Substantial/maximal assistance**.**

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

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

    Nurse: "I understand that Ms. R uses a manual wheelchair. Describe to me how Ms. R wheels herself 50 feet and makes two turns once she is seated in the wheelchair."

    Certified nursing assistant: "She wheels herself."

    Nurse: "She wheels herself without any instructions or physical help?"

    Certified nursing assistant: "Well yes, she needs help to get around turns, so I have to help her and set her on a straight path, but once I do, she wheels herself."

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

    Coding: GG0170R. Wheel 50 feet with two turns 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 patient.

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

    Nurse: "I understand that Mr. G usually uses an electric scooter for longer distances. Once he is seated in the scooter, does he need any help to mobilize himself at least 150 feet?"

    Certified nursing assistant: "He drives the scooter himself…..he's very slow."

    Nurse: "He uses the scooter himself without any instructions or physical help?"

    Certified nursing assistant: "That is correct."

    In this example, the nurse inquired specifically about how Mr. G uses an electric scooter to mobilize himself 150 feet. If this nurse did not ask probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

    Coding: GG0170S. Wheel 150 feet would be coded 06, Independent.

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