# SECTION G: FUNCTIONAL STATUS

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

## G0110: Activities of Daily Living (ADL) Assistance

**G0110. Activities of Daily Living (ADL) Assistance**
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

**Instructions for Rule of 3**

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

**If none of the above are met, code supervision.**

**1. ADL Self-Performance**
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

**Coding:**

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

**2. ADL Support Provided**
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

**Coding:**

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

| | 1. Self-Performance | 2. Support |
|---|---|---|
| | ↓ Enter Codes in Boxes ↓ | |
| A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture | ☐ | ☐ |
| B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet) | ☐ | ☐ |
| C. **Walk in room** - how resident walks between locations in his/her room | ☐ | ☐ |
| D. **Walk in corridor** - how resident walks in corridor on unit | ☐ | ☐ |
| E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair | ☐ | ☐ |
| F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair | ☐ | ☐ |
| G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses | ☐ | ☐ |
| H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration) | ☐ | ☐ |
| I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag | ☐ | ☐ |
| J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers) | ☐ | ☐ |

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

## Item Rationale

### Health-related Quality of Life

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

### Planning for Care

- Individualized care plans should address strengths and weakness, possible reversible causes such as de-conditioning, and adverse side effects of medications or other treatments. These may contribute to needless loss of self-sufficiency. In addition, some neurologic injuries such as stroke may continue to improve for months after an acute event.
- For some residents, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.
- A resident's potential for maximum function is often underestimated by family, staff, and the resident. Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident.
- Many residents might require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or are given adequate time to complete the task while being provided graduated prompting and assistance. This type of supervision requires skill, time, and patience.

**DEFINITIONS**

ADL
Tasks related to personal care; any of the tasks listed in items G0110A-J and G0120.

ADL ASPECTS
Components of an ADL activity. These are listed next to the activity in the item set. For example, the components of G0110H (Eating) are eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition and IV fluids for hydration.

ADL SELF-PERFORMANCE
Measures what the resident **actually did** (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
- Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.

**DEFINITIONS**

**ADL SUPPORT PROVIDED**
Measures the most support **provided by staff** over the last 7 days, even if that level of support only occurred once.

## Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period.
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the resident to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

   To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-9 for an example of using probes when talking to staff.

## Coding Instructions

*For each ADL activity:*

- To assist in coding ADL self performance items, please use the algorithm on page G-6.
- Consider each episode of the activity that occurred during the 7-day look-back period.
- In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).
- Code based on the resident's level of assistance when using special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handle reacher, or adaptive eating utensils.
- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents.

- A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).
- The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code.
- Although it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.
- Because this section involves a two-part evaluation (ADL Self-Performance and ADL Support), each using its own scale, it is recommended that the Self-Performance evaluation be completed for all ADL activities before beginning the ADL Support evaluation.
- **Instructions for the Rule of Three:**
  - When an activity occurs three times at any one given level, code that level.
  - When an activity occurs three times at multiple levels, **code the most dependent**.
    - Example, three times extensive assistance (3) and three times limited assistance (2)—code extensive assistance (3).

    Exceptions are as follows:
    - Total dependence (4)—activity must require full assist every time, and
    - Activity did not occur (8)—activity must not have occurred at all or family and/or non-facility staff provided care 100% of the time for the activity over the entire 7-day period.
  - When an activity occurs at more than one level, but not three times at any one level, apply the following:
    - Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance—this is total dependence).
    - When there are three or more episodes of a combination of full staff performance and weight-bearing assistance—code extensive assistance (3)

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

  - When there are three or more episodes of a combination of full staff performance, weight-bearing assistance, and non-weight-bearing assistance—code limited assistance (2).

- **If none of the above are met, code supervision.**

## Coding Instructions for G0110, Column 1, ADL-Self Performance

- Code 0, independent: if resident completed activity with no help or oversight every time during the 7-day look-back period.
- Code 1, supervision: if oversight, encouragement, or cueing was provided **three** or more times during the last 7 days.
- Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three** or more times during the last 7 days.
- Code 3, extensive assistance: if resident performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:
  - Weight-bearing support provided three or more times.
  - Full staff performance of activity during part but not all of the last 7 days.
- Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- Code 7, activity occurred only once or twice: if the activity occurred but **not** three times or more.
- Code 8, activity did not occur: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

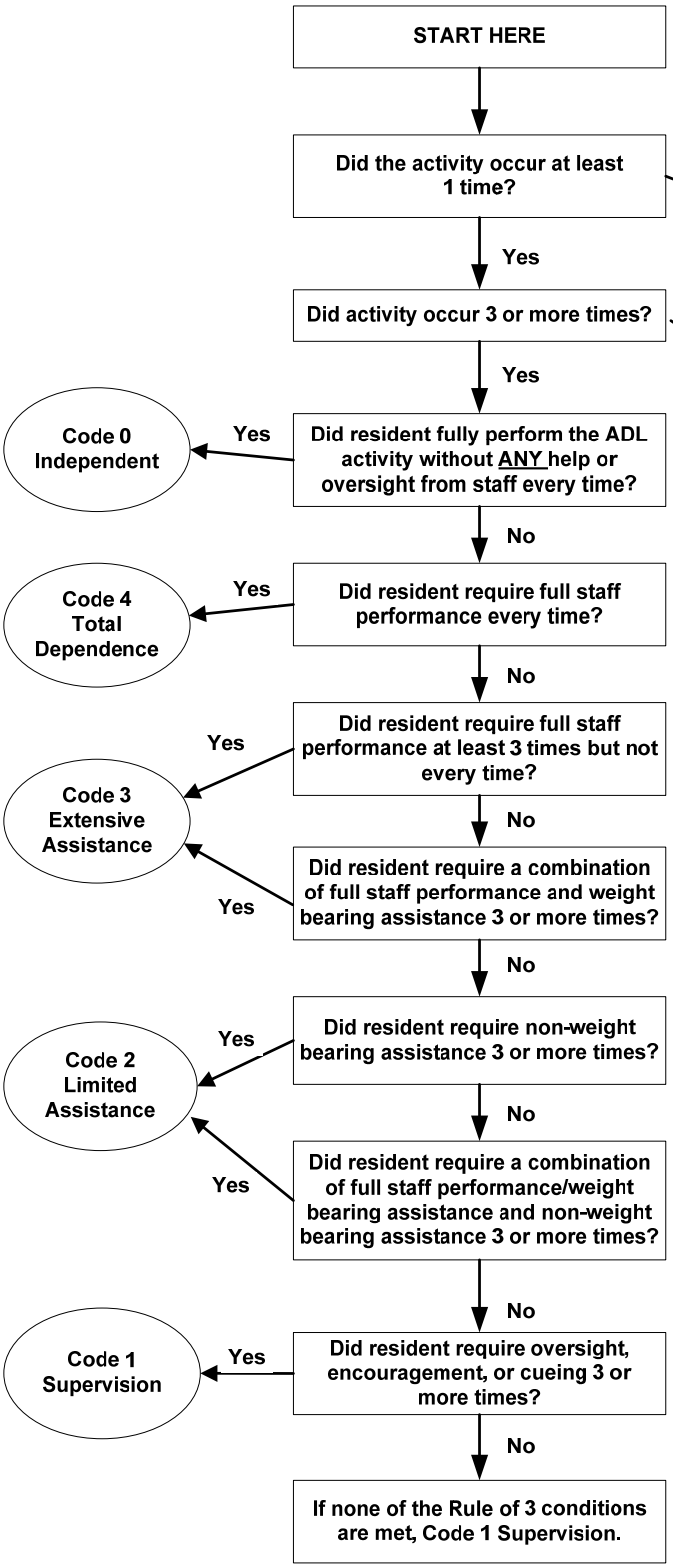
## Coding Instructions for G0110, Column 2, ADL Support

*Code for the **most** support provided over all shifts; code regardless of resident's self-performance classification.*

- Code 0, no setup or physical help from staff: if resident completed activity with no help or oversight.
- Code 1, setup help only: if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- Code 2, one person physical assist: if the resident was assisted by one staff person.
- Code 3, two+ person physical assist: if the resident was assisted by two or more staff persons.
- Code 8, ADL activity itself did not occur during the entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

## ADL Self Performance Algorithm




➢ **INSTRUCTIONS**

Follow the arrows on the flowchart to determine correct coding, starting at the "**Did Activity Occur?**" box.

**Instructions for Rule of 3**

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, **code the most dependent**. Exceptions are: total dependence (4) – activity must require full assist every time; and activity did not occur (8) – activity must not have occurred at all or family and/or non-facility staff provided care 100% of the time for the activity over the entire 7-day period. Example, three times extensive assistance (3) and three times limited assistance (2) – code extensive assistance (3).
- When an activity occurs at more than one level but not three times at any one level, apply the following:
  - Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance - this is total dependence).
  - When there are 3 or more episodes of a combination of full staff performance and weight-bearing assistance - code extensive assistance (3).
  - When there are 3 or more episodes of a combination of full staff performance/weight bearing assistance, and non-weight bearing assistance, code limited assistance (2).

**If none of the above are met, code supervision**

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

## Coding Tips and Special Populations

- Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.
- Do **NOT** record the staff's assessment of the resident's potential capability to perform the ADL activity. The assessment of potential capability is covered in **ADL Functional Rehabilitation Potential** Item (G0900).
- Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
- Do **NOT** include assistance provided by family or other visitors.
- **Some examples for coding for ADL Support Setup Help when the activity involves the following:**
  - Bed Mobility—handing the resident the bar on a trapeze, staff raises the ½ rails for the resident's use and then provides no further help.
  - Transfer—giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
  - Locomotion
    - Walking—handing the resident a walker or cane.
    - Wheeling—unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
  - Dressing—retrieving clothes from the closet and laying out on the resident's bed; handing the resident a shirt.
  - Eating—cutting meat and opening containers at meals; giving one food item at a time.
  - Toilet Use—handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach.
  - Personal Hygiene—providing a washbasin and grooming articles.
- **Supervision**
  - **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
  - General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

- **Coding activity did not occur, 8:**
  - **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
  - **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period.
  - **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.
- **Coding activity occurred only once or twice, 7:**
  - Walk in corridor would be **coded 7, activity occurred only once or twice**: if the resident came out of the room and ambulated in the hallway for a weekly tub bath but otherwise stayed in the room during the 7-day look-back period.
  - Locomotion off unit would be **coded 7, activity occurred only once or twice**: if the resident left the vicinity of his or her room only one or two times to attend an activity in another part of the building.
- **Residents with tube feeding, TPN, or IV fluids**
  - **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
  - **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

## Example of a Probing Conversation with Staff

1. Example of a probing conversation between the RN Assessment Coordinator and a nursing assistant (NA) regarding a resident's bed mobility assessment:

RN: "Describe to me how Mrs. L. moves herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side and positioning herself?"

NA: "She can lay down and sit up by herself, but I help her turn on her side."

RN: "She lays down and sits up without any verbal instructions or physical help?"

NA: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

RN: "How do you help her turn side to side?"

NA: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

RN: "Do you lift her by yourself or does someone help you?"

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

NA: "I do it by myself."
RN: "How many times during the last 7 days did you give this type of help?"
NA: "Every day, probably 3 times each day."

In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of actual assistance Mrs. L. received. Because accurate coding is important as a basis for reporting on the type and amount of care provided, be sure to consider each activity definition fully.

Coding: Bed Mobility ADL assistance would be coded 3 (self-performance) and 2 (support provided), extensive assistance with a one person assist.

## Examples for G0110A, Bed Mobility

1. Mrs. D. can easily turn and position herself in bed and is able to sit up and lie down without any staff assistance at any time during the 7-day look-back period. She requires use of a single side rail that staff place in the up position when she is in bed.

   Coding: G0110A1 would be coded 0, independent.
   G0110A2 would be coded 1, setup help only.

   Rationale: Resident is independent at all times in bed mobility during the 7-day look-back period and needs only setup help.

2. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must verbally remind her to reposition off her right side daily during the 7-day look-back period.

   Coding: G0110A1 would be coded 1, supervision.
   G0110A2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident requires staff supervision, cueing, and reminders for repositioning more than three times during the look-back period.

3. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must sometimes cue the resident and guide (non-weight-bearing assistance) the resident to place her hands on the side rail and encourage her to change her position when in bed daily over the 7-day look-back period.

   Coding: G0110A1 would be coded 2, limited assistance.
   G0110A2 would be coded 2, one person physical assist.

   Rationale: Resident requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

4. Mr. Q. has slid to the foot of the bed four times during the 7-day look-back period. Two staff members had to physically lift and reposition him toward the head of the bed. Mr. Q. was able to assist by bending his knees and pushing with legs when reminded by staff.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110A1 would be coded 3, extensive assistance.
G0110A2 would be coded 3, two+ persons physical assist.

Rationale: Resident required weight-bearing assistance of two staff members on four occasions during the 7-day look-back period with bed mobility.

5. Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every 2 hours without any participation at any time from her at any time during the 7-day look-back period. She must be physically assisted to a seated position in bed when reading.

Coding: G0110A1 would be coded 4, total dependence.
G0110A2 would be coded 3, two+ persons physical assist.

Rationale: Resident did not participate at any time during the 7-day look-back period and required two staff to position her in bed.

## Examples for G0110B, Transfer

1. When transferring from bed to chair or chair back to bed, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk from the bed to chair and chair back to the bed every day during the 7-day look back period.

Coding: G0110B1 would be coded 0, independent.
G0110B2 would be coded 0, no setup or physical help from staff.

Rationale: Resident is independent each and every time she transferred during the 7-day look-back period and required no setup or physical help from staff.

2. Staff must supervise the resident as she transfers from her bed to wheelchair daily. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

Coding: G0110B1 would be coded 1, supervision.
G0110B2 would be coded 1, setup help only.

Rationale: Resident requires staff supervision, cueing, and reminders for safe transfer. This activity happened daily over the 7-day look-back period.

3. Mrs. H. is able to transfer from the bed to chair when she uses her walker. Staff place the walker near her bed and then assist the resident with guided maneuvering as she transfers. The resident was noted to transfer from bed to chair six times during the 7-day look-back period.

Coding: G0110B1 would be coded 2, limited assistance.
G0110B2 would be coded 2, one person physical assist.

Rationale: Resident requires staff to set up her walker and provide non-weight-bearing assistance when she is ready to transfer. The activity happened six times during the 7-day look-back period.

4. Mrs. B. requires weight-bearing assistance of one staff member to partially lift and support her when being transferred. The resident was noted to have been transferred 14 times in the 7-day look-back period and each time required weight-bearing assistance.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110B1 would be coded 3, extensive assistance.
G0110B2 would be coded 2, one person physical assist.

Rationale: Resident partially participates in the task of transferring. The resident was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one staff member.

5. Mr. T. is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer him to a reclining chair daily using a mechanical lift. Mr. T. is unable to assist or participate in any way.

Coding: G0110B1 would be coded 4, total dependence.
G0110B2 would be coded 3, two+ persons physical assist.

Rationale: Resident did not participate and required two staff to transfer him out of his bed. The resident was transferred out of bed to the chair daily during the 7-day look-back period.

6. Mrs. D. is post-operative for extensive surgical procedures. Because of her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest. During the 7-day look-back period the resident was not moved from the bed.

Coding: G0110B1 would be coded 8, activity did not occur.
G0110B2 would be coded 8, ADL activity itself did not occur during entire period.

Rationale: Activity did not occur.

7. Mr. M. has Parkinson's disease and needs weight-bearing assistance of two staff to transfer from his bed to his wheelchair. During the 7-day look-back period, Mr. M. was transferred once from the bed to the wheelchair and once from wheelchair to bed.

Coding: G0110B1 would be coded 7, activity occurred only once or twice.
G0110B2 would be coded 3, two+ persons physical assist.

Rationale: The activity happened only twice during the look-back period, with the support of two staff members.

### Examples for G0110C, Walk in Room

1. Mr. R. is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from staff at all during the entire 7-day look-back period.

Coding: G0110C1 would be coded 0, independent.
G0110C2 would be coded 0, no setup or physical help from staff.

Rationale: Resident is independent.

2. Mr. B. was able to walk in his room daily, but a staff member needed to cue and stand by during ambulation because the resident has had a history of an unsteady gait.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110C1 would be coded 1, supervision.
G0110C2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires staff supervision, cueing, and reminders daily while walking in his room, but did not need setup or physical help from staff.

3. Mr. K. is able to walk in his room, and, with hand-held assist from one staff member, the resident was noted to ambulate daily during the 7-day look-back period.

Coding: G0110C1 would be coded 2, limited assistance.
G0110C2 would be coded 2, one person physical assist.

Rationale: Resident requires hand-held (non-weight-bearing) assistance of one staff member daily for ambulation in his room.

4. Mr. A. has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to help support him when he selects clothing from his closet. During the 7-day look-back period the resident was able to ambulate with weight-bearing assistance from one staff member in his room four times.

Coding: G0110C1 would be coded 3, extensive assistance.
G0110C2 would be coded 2, one person physical assist.

Rationale: The resident was able to ambulate in his room four times during the 7-day look-back period with weight-bearing assistance of one staff member.

5. Mr. J. is attending physical therapy for transfer and gait training. He does not ambulate on the unit or in his room at this time. He calls for assistance to stand pivot to a commode next to his bed.

Coding: G0110C1 would be coded 8, activity did not occur.
G0110C2 would be coded 8, ADL activity itself did not occur during entire period.

Rationale: Activity did not occur.

## Examples for G0110D, Walk in Corridor

1. Mr. X. ambulated daily up and down the hallway on his unit with a cane and did not require any setup or physical help from staff at any time during the 7-day look-back period.

Coding: G0110D1 would be coded 0, independent.
G0110D2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires no setup or help from the staff at any time during the entire 7-day look-back period.

2. Staff members provided verbal cueing while resident was walking in the hallway every day during the 7-day look-back period to ensure that the resident walked slowly and safely.

Coding: G0110D1 would be coded 1, supervision.
G0110D2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires staff supervision, cueing, and reminders daily while ambulating in the hallway during the 7-day look-back period.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

3. Mrs. Q. requires verbal cueing and physical guiding of her hand placement on the walker when walking down the unit hallway. She needs frequent verbal reminders of how to use her walker, where to place her hands, and to pick up her feet. Mrs. Q. needs to be physically guided to the day room. During the 7-day look-back period the resident was noted to ambulate in the hallway daily and required the above-mentioned support from one staff member.

   Coding: G0110D1 would be coded 2, limited assistance.
   G0110D2 would be coded 2, one person physical assist.

   Rationale: Resident requires non-weight-bearing assistance of one staff member for safe ambulation daily during the 7-day look-back period.

4. A resident had back surgery 2 months ago. Two staff members must physically support the resident as he is walking down the hallway because of his unsteady gait and balance problem. During the 7-day look-back period the resident was ambulated in the hallway three times with physical assist of two staff members.

   Coding: G0110D1 would be coded 3, extensive assistance.
   G0110D2 would be coded 3, two+ persons physical assist.

   Rationale: The resident was ambulated three times during the 7-day look-back period, with the resident partially participating in the task. Two staff members were required to physically support the resident so he could ambulate.

5. Mrs. J. ambulated in the corridor once with supervision and once with non-weight-bearing assistance of one staff member during the 7-day look-back period.

   Coding: G0110D1 would be coded 7, activity occurred only once or twice.
   G0110D2 would be coded 2, one person physical assist.

   Rationale: The activity occurred only twice during the look-back period. It does not matter that the level of assistance provided by staff was at different levels. During ambulation, the most support provided was physical help by one staff member.

### Examples for G0110E, Locomotion on Unit

1. Mrs. L. is on complete bed rest. During the 7-day look-back period she did not get out of bed or leave the room.

   Coding: G0110E1 would be coded 8, activity did not occur.
   G0110E2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: The resident was on bed rest during the look-back period and never left her room.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

## Examples for G0110F, Locomotion off Unit

1. Mr. R. does not like to go off his nursing unit. He prefers to stay in his room or the day room on his unit. He has visitors on a regular basis, and they visit with him in the day room on the unit. During the 7-day look-back period the resident did not leave the unit for any reason.

   Coding: G0110F1 would be coded 8, activity did not occur.
   G0110F2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: Activity did not occur at all.

2. Mr. Q. is a wheelchair-bound and is able to self-propel on the unit. On two occasions during the 7-day look-back period, he self-propelled off the unit into the courtyard.

   Coding: G0110F1 would be coded 7, activity occurred only once or twice.
   G0110F2 would be coded 0, no setup or physical help from staff.

   Rationale: The activity of going off the unit happened only twice during the look-back period with no help or oversight from staff.

3. Mr. H. enjoyed walking in the nursing garden when weather permitted. Due to inclement weather during the assessment period, he required various levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one staff person and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.

   Coding: G0110F1 would be coded 1, supervision.
   G0110F2 would be coded 2, one person physical assist.

   Rationale: Activity did not occur at any one level for three times and he did not require physical assistance for at least three times. The most support provided by staff was one person assist.

## Examples for G0110G, Dressing

1. Mrs. C. did not feel well and chose to stay in her room. She requested to stay in night clothes and rest in bed for the entire 7-day look-back period. Each day, after washing up, Mrs. C. changed night clothes with staff assistance to guide her arms and assist in guiding her nightgown over her head and buttoning the front.

   Coding: G0110G1 would be coded 2, limited assistance.
   G0110G2 would be coded 2, one person physical assist.

   Rationale: Resident was highly involved in the activity and changed clothing daily with non-weight-bearing assistance from one staff member during the 7-day look-back period.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

## Examples for G0110H, Eating

1. After staff deliver Mr. K.'s meal tray, he consumes all food and fluids without any cueing or physical help during the entire 7-day look-back period.

   Coding: G0110H1 would be coded 0, independent.
   G0110H2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident is completely independent in eating during the entire 7-day look-back period.

2. One staff member had to verbally cue the resident to eat slowly and drink throughout each meal during the 7-day look-back period.

   Coding: G0110H1 would be coded 1, supervision.
   G0110H2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident required staff supervision, cueing, and reminders for safe meal completion daily during the 7-day look-back period.

3. Mr. V. is able to eat by himself. Staff must set up the tray, cut the meat, open containers, and hand him the utensils. Each day during the 7-day look-back period, Mr. V. required more help during the evening meal, as he was tired and less interested in completing his meal. In the evening, in addition to encouraging the resident to eat and handing him his utensils and cups, staff must also guide the resident's hand so he will get the utensil to his mouth.

   Coding: G0110H1 would be coded 2, limited assistance.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: Resident is unable to complete the evening meal without staff providing him non-weight-bearing assistance daily.

4. Mr. F. begins eating each meal daily by himself. During the 7-day look-back period, after he had eaten only his bread, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

   Coding: G0110H1 would be coded 3, extensive assistance.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: Resident partially participated in the task daily at each meal, but one staff member provided weight-bearing assistance with some portion of each meal.

5. Mrs. U. is severely cognitively impaired. She is unable to feed herself. During the 7-day look-back period, one staff member had to assist her with eating every meal.

   Coding: G0110H1 would be coded 4, total dependence.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: Resident did not participate and required one staff person to feed her all of her meal during the 7-day look-back period.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

6. Mrs. D. receives all of her nourishment via a gastrostomy tube. She did not consume any food or fluid by mouth. During the 7-day look-back period, she did not participate in the gastrostomy nourishment process.

   Coding: G0110H1 would be coded 4, total dependence.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: During the 7-day look-back period, she did not participate in eating and/or receiving of her tube feed during the entire period. She required full staff performance of these functions.

## Examples for G0110I, Toilet Use

1. Mrs. L. transferred herself to the toilet, adjusted her clothing, and performed the necessary personal hygiene after using the toilet without any staff assistance daily during the entire 7-day look-back period.

   Coding: G0110I1 would be coded 0, independent.
   G0110I2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident was independent in all her toileting tasks.

2. Staff member must remind resident to toilet frequently during the day and to unzip and zip pants and to wash his hands after using the toilet. This occurred multiple times each day during the 7-day look-back period.

   Coding: G0110I1 would be coded 1, supervision.
   G0110I2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident required staff supervision, cueing and reminders daily.

3. Staff must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. . This occurred multiple times each day during the 7-day look-back period.

   Coding: G0110I1 would be coded 2, limited assistance.
   G0110I2 would be coded 2, one person physical assist.
   Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

4. Mrs. M. has had recent bouts of vertigo. During the 7-day look-back period, the resident required one staff member to assist and provide weight-bearing support to her as she transferred to the bedside commode four times.

   Coding: G0110I1 would be coded 3, extensive assistance.
   G0110I2 would be coded 2, one person physical assist.
   Rationale: During the 7-day look-back period, the resident required weight-bearing assistance with the support of one staff member to use the commode four times.

# G0110: Activities of Daily Living (ADL) Assistance (cont.)

5. Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Staff were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for her elimination and personal hygiene needs several times each day.

   Coding: G0110I1 would be coded 4, total dependence.
   G0110I2 would be coded 2, one person physical assist.

   Rationale: Resident did not participate and required one staff person to provide total care for toileting and personal hygiene each time during the entire 7-day look-back period.

## Examples for G0110J, Personal Hygiene

1. The nurse assistant takes Mr. L.'s comb, toothbrush, and toothpaste from the drawer and places them at the bathroom sink. Mr. L. combs his own hair and brushes his own teeth daily. During the 7-day look-back period, he required cueing to brush his teeth on three occasions.

   Coding: G0110J1 would be coded 1, supervision.
   G0110J2 would be coded 1, setup help only.

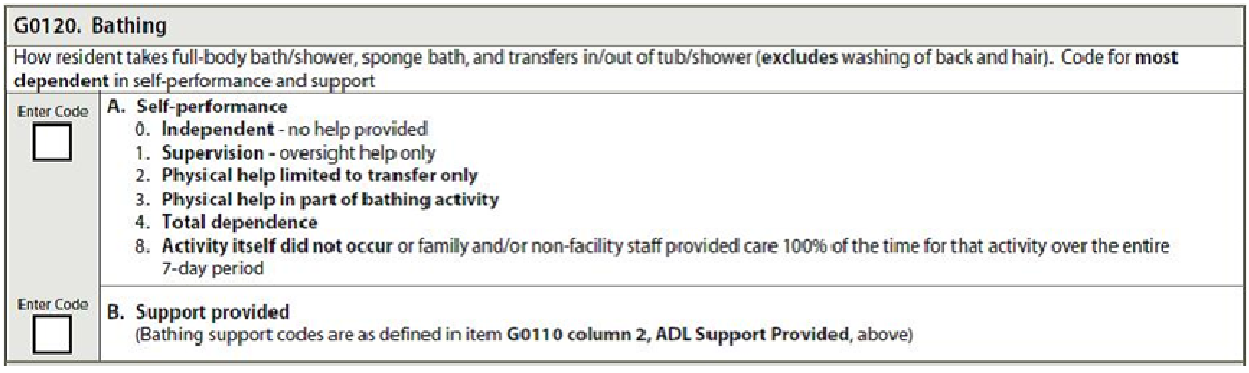
   Rationale: Staff placed grooming devices at sink for his use, and during the 7-day look-back period staff provided cueing three times.

2. Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her.

   Coding: G0110J1 would be coded 3, extensive assistance.
   G0110J2 would be coded 2, one person physical assist.

   Rationale: A staff member had to complete part of the activity for the resident 3 days during the look-back period; the assistance was non-weight-bearing.

# G0120: Bathing



**G0120. Bathing**

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

**A. Self-performance**
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Enter Code ☐

**B. Support provided**
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

# G0120: Bathing (cont.)

**DEFINITIONS**

BATHING
How the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.

## Item Rationale

### Health-related Quality of Life

- The resident's choices regarding his or her bathing schedule should be accommodated when possible so that facility routine does not conflict with resident's desired routine.

### Planning for Care

- The care plan should include interventions to address the resident's unique needs for bathing. These interventions should be periodically evaluated and, if objectives were not met, alternative approaches developed to encourage maintenance of bathing abilities.

## Coding Instructions for G0120A, Self Performance

*Code for the maximum amount of assistance the resident received during the bathing episodes.*

- Code 0, independent: if the resident required no help from staff.
- Code 1, supervision: if the resident required oversight help only.
- Code 2, physical help limited to transfer only: if the resident is able to perform the bathing activity, but required help with the transfer only.
- Code 3, physical help in part of bathing activity: if the resident required assistance with some aspect of bathing.
- Code 4, total dependence: if the resident is unable to participate in any of the bathing activity.
- Code 8, ADL activity itself did not occur during entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

## Coding Instructions for G0120B, Support Provided

- Bathing support codes are as defined **ADL Support Provided** item (G0110), Column 2.

## Coding Tips

- Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, **Column 1 (Self-Performance),** do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADL's in the 7-day look-back period.
- If a nursing home has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the resident self-performance as supervision, even if the supervision is precautionary because the resident is still being individually supervised. Support for bathing in this instance would be coded according to whether or not the staff had to actually assist the resident during the bathing activity.

# G0120: Bathing (cont.)

## Examples

1. Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.

   Coding: G0120A would be coded 1, supervision.
   G0120B would be coded 0, no setup or physical help from staff.

   Rationale: Resident needed only supervision to perform the bathing activity with no setup or physical help from staff.

2. For one bath, the resident received physical help of one person to position self in bathtub. However, because of her fluctuating moods, she received total help for her other bath from one staff member.

   Coding: G0120A would be coded 4, total dependence.
   G0120B would be coded 2, one person physical assist.

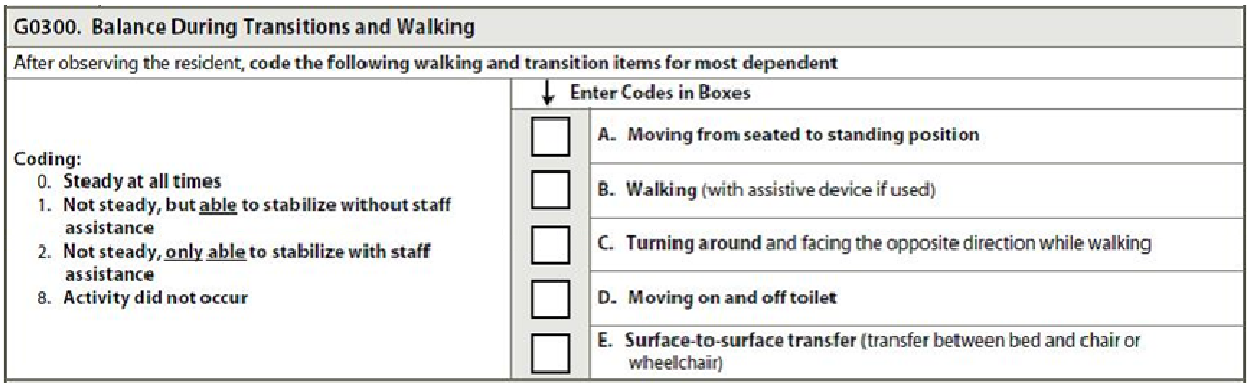
   Rationale: Coding directions for bathing state, "code for most dependent in self performance and support." Resident's most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one staff person.

3. On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, the resident had physical help of one person to get into tub but washed himself completely.

   Coding: G0120A would be coded 3, physical help in part of bathing activity.
   G0120B would be coded 2, one person physical assist.

   Rationale: Resident's most dependent episode during the 7-day look-back period was assistance with part of the bathing activity from one staff person.

# G0300: Balance During Transitions and Walking



| G0300. Balance During Transitions and Walking | | |
|---|---|---|
| After observing the resident, code the following walking and transition items for most dependent | | |
| | ↓ Enter Codes in Boxes | |
| Coding:<br>0. Steady at all times<br>1. Not steady, but able to stabilize without staff assistance<br>2. Not steady, only able to stabilize with staff assistance<br>8. Activity did not occur | ☐ | A. Moving from seated to standing position |
| | ☐ | B. Walking (with assistive device if used) |
| | ☐ | C. Turning around and facing the opposite direction while walking |
| | ☐ | D. Moving on and off toilet |
| | ☐ | E. Surface-to-surface transfer (transfer between bed and chair or wheelchair) |

# G0300: Balance During Transitions and Walking (cont.)

## Item Rationale

### Health-related Quality of Life

- Individuals with impaired balance and unsteadiness during transitions and walking
  - — are at increased risk for falls;
  - — often are afraid of falling;
  - — may limit their physical and social activity, becoming socially isolated and despondent about limitations; and
  - — can become increasingly immobile.

**DEFINITIONS**

INTERDISCIPLINARY TEAM
Refers to a team that includes staff from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.

### Planning for Care

- Individuals with impaired balance and unsteadiness should be evaluated for the need for
  - — rehabilitation or assistive devices;
  - — supervision or physical assistance for safety; and/or
  - — environmental modification.
- Care planning should focus on preventing further decline of function, and/or on return of function, depending on resident-specific goals.
- Assessment should identify all related risk factors in order to develop effective care plans to maintain current abilities, slow decline, and/or promote improvement in the resident's functional ability.

## Steps for Assessment

1. Complete this assessment for all residents.
2. Throughout the 7-day look-back period, interdisciplinary team members should carefully observe and document observations of the resident during transitions from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed and bed to wheelchair (for residents who use a wheelchair).
3. If staff have not systematically documented the resident's stability in these activities at least once during the 7-day look-back period, use the following process to code these items:
   a. Before beginning the activity, explain what the task is and what you are observing for.
   b. Have assistive devices the resident normally uses available.
   c. Start with the resident sitting up on the edge of his or her bed, in a chair or in a wheelchair (if he or she generally uses one).
   d. Ask the resident to stand up and stay still for 3-5 seconds. **Moving from seated to standing position (G0300A) should be rated at this time.**
   e. Ask the resident to walk approximately 15 feet using his or her usual **assistive device**. **Walking (G0300B) should be rated at this time.**

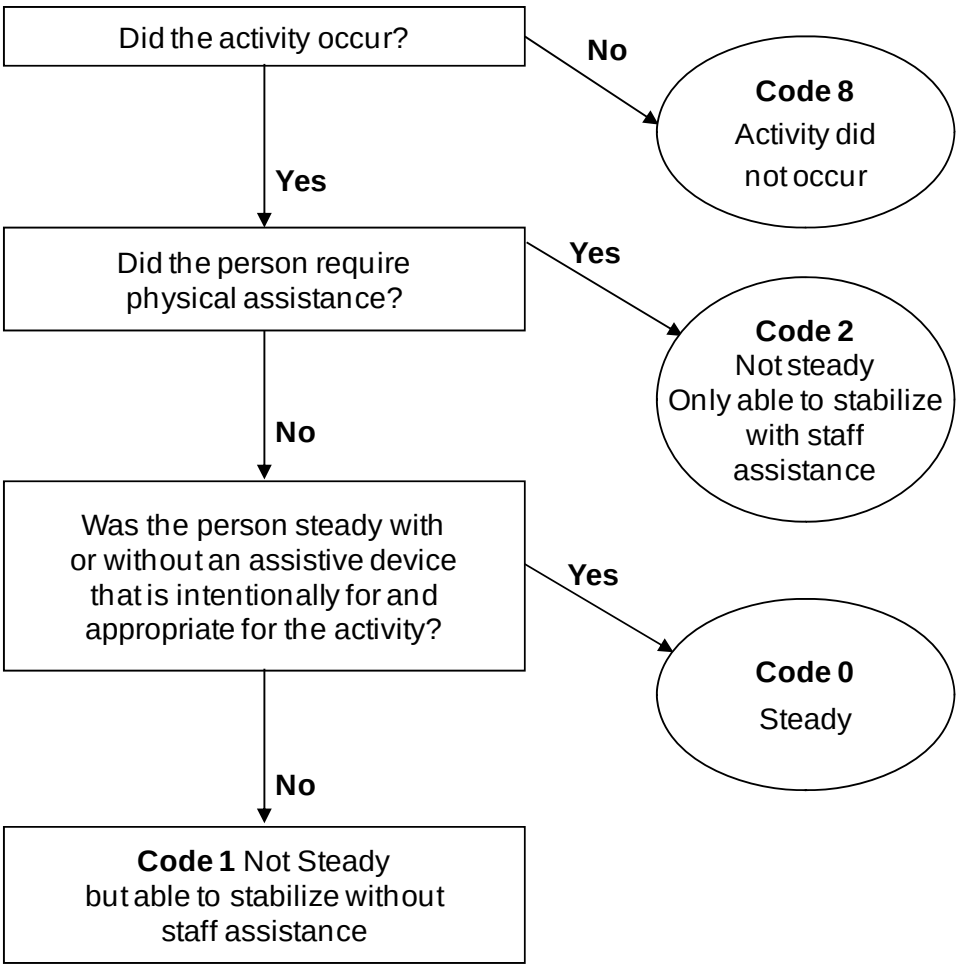
# G0300: Balance During Transitions and Walking (cont.)

f. Ask the resident to turn around. **Turning around (G0300C) should be rated at this time.**

g. Ask the **resident to walk or wheel** from a starting point in his or her room into the bathroom, **prepare for toileting** as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet. **Moving on and off toilet (G0300D) should be rated at this time.**

h. Ask residents who are not ambulatory and who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed. **Surface-to-surface transfer should be rated at this time (G0300E).**

## Balance During Transitions and Walking Algorithm



# G0300: Balance During Transitions and Walking (cont.)

## Coding Instructions G0300A, Moving from Seated to Standing Position

*Code for the least steady episode, using assistive device if applicable.*

- Code 0, steady at all times:
  - — If all of the transitions from seated to standing position and from standing to seated position observed during the 7-day look-back period are steady.
  - — If resident is stable when standing up using the arms of a chair or an assistive device identified for this purpose (such as a walker, locked wheelchair, or grab bar).
  - — If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
  - — If resident appears steady and not at risk of a fall when standing up.
- Code 1, not steady, but able to stabilize without staff assistance:
  - — If any of transitions from seated to standing position or from standing to seated position during the 7-day look-back period are not steady, but the resident is able to stabilize without assistance from staff or object (e.g., a chair or table).
  - — If the resident is unsteady using an assistive device but does not require staff assistance to stabilize.
  - — If the resident attempts to stand, sits back down, then is able to stand up and stabilize without assistance from staff or object.
  - — Residents coded in this category appear at increased risk for falling when standing up.

**DEFINITIONS**

UNSTEADY Residents may appear unbalanced or move with a sway or with uncoordinated or jerking movements that make them unsteady. They might exhibit unsteady gaits such as fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

- Code 2, not steady, only able to stabilize with staff assistance:
  - — If any of transitions from seated to standing or from standing to sitting are not steady, and the resident cannot stabilize without assistance from staff.
  - — If the resident cannot stand but can transfer unassisted without staff assistance.
  - — If the resident returned back to a seated position or was unable to move from a seated to standing or from standing to sitting position during the look-back period.
  - — Residents coded in this category appear at high risk for falling during transitions.
  - — If a lift device (a mechanical device operated by another person) is used because the resident requires staff assistance to stabilize, code as 2.
- Code 8, activity did not occur: if the resident did not move from seated to standing position during the 7-day look-back period.

# G0300: Balance During Transitions and Walking (cont.)

## Examples for G0300A, Moving from Seated to Standing Position

1. A resident sits up in bed, stands, and begins to sway, but steadies herself and sits down smoothly into her wheelchair.

   Coding: G0300A would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident was unsteady, but she was able to stabilize herself without assistance from staff.

2. A resident requires the use of a gait belt and physical assistance in order to stand.

   Coding: G0300A would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: Resident required staff assistance to stand during the observation period.

3. A resident stands steadily by pushing himself up using the arms of a chair.

   Coding: G0300A would be coded 0, steady at all times.

   Rationale: Even though the resident used the arms of the chair to push himself up, he was steady at all times during the activity.

4. A resident locks his wheelchair and uses the arms of his wheelchair to attempt to stand. On the first attempt, he rises about halfway to a standing position then sits back down. On the second attempt, he is able to stand steadily.

   Coding: G0300A would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Even though the second attempt at standing was steady, the first attempt suggests he is unsteady and at risk for falling during this transition.

## Coding Instructions G0300B, Walking (with Assistive Device if Used)

*Code for the least steady episode, using assistive device if applicable.*

- Code 0, steady at all times:
  - — If during the 7-day look-back period the resident's walking (with assistive devices if used) is steady at all times.
  - — If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device and is steady while walking with it.
  - — Residents in this category do not appear at risk for falls.
  - — Residents who walk with an abnormal gait and/or with an assistive device can be steady, and if they are they should be coded in this category.
- Code 1, not steady, but able to stabilize without staff assistance:
  - — If during the 7-day look-back period the resident appears unsteady while walking (with assistive devices if used) but does not require staff assistance to stabilize.
  - — Residents coded in this category appear at risk for falling while walking.

# G0300: Balance During Transitions and Walking (cont.)

- Code 2, not steady, only able to stabilize with staff assistance:
  - — If during the-7-day look-back period the resident at any time appeared unsteady and required staff assistance to be stable and safe while walking.
  - — If the resident fell when walking during the look-back period.
  - — Residents coded in this category appear at high risk for falling while walking.
- Code 8, activity did not occur:
  - — If the resident did not walk during the 7-day look-back period.

## Examples for G0300B, Walking (with Assistive Device if Used)

1. A resident with a recent stroke walks using a hemi-walker in her right hand because of left-sided weakness. Her gait is slow and short-stepped and slightly unsteady as she walks, she leans to the left and drags her left foot along the ground on most steps. She has not had to steady herself using any furniture or grab bars.

   Coding: G0300B would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident's gait is unsteady with or without an assistive device but does not require staff assistance.

2. A resident with Parkinson's disease ambulates with a walker. His posture is stooped, and he walks slowly with a short-stepped shuffling gait. On some occasions, his gait speeds up, and it appears he has difficulty slowing down. On multiple occasions during the 7-day observation period he has to steady himself using a handrail or a piece of furniture in addition to his walker.

   Coding: G0300B would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident has an unsteady gait but can stabilize himself using an object such as a handrail or piece of furniture.

3. A resident who had a recent total hip replacement ambulates with a walker. Although she is able to bear weight on her affected side, she is unable to advance her walker safely without staff assistance.

   Coding: G0300B would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: Resident requires staff assistance to walk steadily and safely at any time during the observation period.

4. A resident with multi-infarct dementia walks with a short-stepped, shuffling-type gait. Despite the gait abnormality, she is steady.

   Coding: G0300B would be coded 0, steady at all times.

   Rationale: Resident walks steadily (with or without a normal gait and/or the use of an assistive device) at all times during the observation period.

# G0300: Balance During Transitions and Walking (cont.)

## Coding Instructions G0300C, Turning Around and Facing the Opposite Direction while Walking

*Code for the least steady episode, using an assistive device if applicable.*

- Code 0, steady at all times:
  - — If all observed turns to face the opposite direction are steady without assistance of a staff during the 7-day look-back period.
  - — If the resident is stable making these turns when using an assistive device.
  - — If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
  - — Residents coded as 0 should not appear to be at risk of a fall during a transition.
- Code 1, not steady, but able to stabilize without staff assistance:
  - — If any transition that involves turning around to face the opposite direction is not steady, but the resident stabilizes without assistance from a staff.
  - — If the resident is unstable with an assistive device but does not require staff assistance.
  - — Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - — If any transition that involves turning around to face the opposite direction is not steady, and the resident cannot stabilize without assistance from a staff.
  - — If the resident fell when turning around to face the opposite direction during the look-back period.
  - — Residents coded in this category appear at high risk for falling during transitions.
- Code 8, activity did not occur:
  - — If the resident did not turn around to face the opposite direction while walking during the 7-day look-back period.

## Examples for G0300C, Turning Around and Facing the Opposite Direction while Walking

1. A resident with Alzheimer's disease frequently wanders on the hallway. On one occasion, a nursing assistant noted that he was about to fall when turning around. However, by the time she got to him, he had steadied himself on the handrail.

   Coding: G0300C would be coded 1, Not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when turning but able to steady himself on an object, in this instance, a handrail.

# G0300: Balance During Transitions and Walking (cont.)

2. A resident with severe arthritis in her knee ambulates with a single-point cane. A nursing assistant observes her lose her balance while turning around to sit in a chair. The nursing assistant is able to get to her before she falls and lowers her gently into the chair.

   Coding: G0300C would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: The resident was unsteady when turning around and would have fallen without staff assistance.

## Coding for G0300D, Moving on and off Toilet

*Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable. Include stability while manipulating clothing to allow toileting to occur in this rating.*

- Code 0, steady at all times:
  - If all of the observed transitions on and off the toilet during the 7-day look-back period are steady without assistance of a staff.
  - If the resident is stable when transferring using an assistive device or object identified for this purpose.
  - If an assistive device is used (e.g., grab bar), the resident appropriately plans and integrates the use of the device into the transition activity.
  - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transitions on or off the toilet during the7-day look-back period are not steady, **but** the resident stabilizes **without** assistance from a staff.
  - If resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transitions on or off the toilet during the 7-day look-back period are not steady, and the resident cannot stabilize without assistance from a staff.
  - If the resident fell when moving on or off the toilet during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If lift device is used.
- Code 8, activity did not occur:
  - If the resident did not transition on and off the toilet during the 7-day look-back period.

# G0300: Balance During Transitions and Walking (cont.)

## Examples for G0300D, Moving on and off Toilet

1. A resident sits up in bed, stands up, pivots and grabs her walker. She then steadily walks to the bathroom where she pivots, pulls down her underwear, uses the grab bar and smoothly sits on the commode using the grab bar to guide her. After finishing, she stands and pivots using the grab bar and smoothly ambulates out of her room with her walker.

   Coding: G0300D would be coded 0, steady at all times.

   Rationale: This resident's use of the grab bar was not to prevent a fall after being unsteady, but to maintain steadiness during her transitions. The resident was able to smoothly and steadily transfer onto the toilet, using a grab bar.

2. A resident wheels her wheelchair into the bathroom, stands up, begins to lift her dress, sways, and grabs onto the grab bar to steady herself. When she sits down on the toilet, she leans to the side and must push herself away from the towel bar to sit upright steadily.

   Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when disrobing to toilet but was able to steady herself with a grab bar.

3. A resident wheels his wheelchair into the bathroom, stands, begins to pull his pants down, sways, and grabs onto the grab bar to steady himself. When he sits down on the toilet, he leans to the side and must push himself away from the sink to sit upright steadily. When finished, he stands, sways, and then is able to steady himself with the grab bar.

   Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when disrobing to toilet but was able to steady himself with a grab bar.

## Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)

*Code for the least steady episode.*

- Code 0, steady at all times:
  - — If all of the observed transfers during the 7-day look-back period are steady without assistance of a staff.
  - — If the resident is stable when transferring using an assistive device identified for this purpose.
  - — If an assistive device or equipment is used, the resident uses it independently and appropriately plans and integrates the use of the device into the transition activity.
  - — Residents **coded 0** should not appear to be at risk of a fall during a transition.

## G0300: Balance During Transitions and Walking (cont.)

- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transfers during the look-back period are not steady, but the resident stabilizes without assistance from a staff.
  - If the resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transfers during the 7-day look-back period are not steady, and the resident can only stabilize with assistance from a staff.
  - If the resident fell during a surface-to-surface transfer during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If a lift device (a mechanical device that is completely operated by another person) is used, and this mechanical device is being used because the resident requires staff assistance to stabilize, **code 2**.
- Code 8, activity did not occur:
  - If the resident did not transfer from bed and chair or wheelchair during the 7-day look-back period.

### Examples for G0300E, Surface-to-Surface Transfer (Transfer Between Bed and Chair or Wheelchair)

1. A resident who uses her wheelchair for mobility stands up from the edge of her bed, pivots, and sits in her locked wheelchair in a steady fashion.

   Coding: G0300E would be coded 0, steady at all times.

   Rationale: The resident was steady when transferring from bed to wheelchair and did not require staff assistance to make a steady transfer.

2. A resident who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his chair.

   Coding: G0300E would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: The resident was unsteady when transferring from bed to wheelchair and required staff assistance to make a steady transfer.

3. A resident with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.

   Coding: G0300E would be coded 1, not steady, but able to stabilize without staff assistance.

# G0300: Balance During Transitions and Walking (cont.)

Rationale: The resident was unsteady when transferring from bed to wheelchair but did not require staff assistance to complete the activity.

4. A resident who uses her wheelchair for mobility stands up from the edge of her bed, sways to the right, but then is quickly able to pivot and sits in her locked wheelchair in a steady fashion.

   Coding: G0300E would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when transferring from bed to wheelchair but was able to steady herself without staff assistance or an object.

## Additional examples for G0300A-E, Balance during Transitions and Walking

1. A resident sits up in bed, stands up, pivots and sits in her locked wheelchair. She then wheels her chair to the bathroom where she stands, pivots, lifts gown and smoothly sits on the commode.

   Coding: G0300A, G0300D, G0300E would be coded 0, steady at all times.

   Rationale: The resident was steady during each activity.

# G0400: Functional Limitation in Range of Motion

| G0400. Functional Limitation in Range of Motion | | |
|---|---|---|
| **Code for limitation** that interfered with daily functions or placed resident at risk of injury | | |
| **Coding:**<br>0. **No impairment**<br>1. **Impairment on one side**<br>2. **Impairment on both sides** | ↓ **Enter Codes in Boxes** | |
| | ☐ | **A. Upper extremity** (shoulder, elbow, wrist, hand) |
| | ☐ | **B. Lower extremity** (hip, knee, ankle, foot) |

Intent: The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places him or her at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM taking into account activities that the resident is able to perform.

**DEFINITIONS**

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

## Item Rationale

### Health-related Quality of Life

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

### Planning for Care

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

# G0400: Functional Limitation in Range of Motion (cont.)

## Steps for Assessment

1. Review the medical record for references to functional range of motion limitation during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM.
3. Coding for functional ROM limitations is a 3 step process:
   - Test the resident's upper and lower extremity ROM (See #6 below for examples).
   - If the resident is noted to have limitation of upper and/or lower extremity ROM, review G0110 and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury.
   - Code G0400 A/B as appropriate based on the above assessment.
4. Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).
5. Staff observations of various activities, including ADLs, may be used to determine if any ROM limitations impact the resident's functional abilities.
6. Although this item codes for the presence or absence of functional limitation related to ROM; thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:
   - Ask the resident to follow your verbal instructions for each movement.
   - Demonstrate each movement (e.g., ask the resident to do what you are doing).
   - Actively assist the resident with the movements by supporting his or her extremity and guiding it through the joint ROM.

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

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

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

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

# G0400: Functional Limitation in Range of Motion (cont.)

## Coding Tips

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

## Coding Instructions for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

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

## Examples for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

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

   Coding: G0400A would be coded 1, upper extremity impairment on one side.
   G0400B would be coded 1, lower extremity impairment on one side.

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

## G0400: Functional Limitation in Range of Motion (cont.)

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

   Coding: G0400A would be coded 1, upper extremity impairment on one side.
   G0400B would be coded 0, no impairment.

   Rationale: Impairment due to shoulder surgery affects only one side of her upper extremities.

3. The resident has a diagnosis of Parkinson's and ambulates with a shuffling gate. The resident has had 3 falls in the past quarter and often forgets his walker which he needs to ambulate. He has tremors of both upper extremities that make it very difficult to feed himself, brush his teeth or write.

   Coding: G0400A would be coded 2, upper extremity impairment on both sides.
   G0400B would be coded 2, lower extremity impairment on both sides.

   Rationale: Impairment due to Parkinson's disease affects the resident at the upper and lower extremities on both sides.

## G0600: Mobility Devices

| G0600. Mobility Devices | |
|---|---|
| ↓ Check all that were normally used | |
| ☐ | A. Cane/crutch |
| ☐ | B. Walker |
| ☐ | C. Wheelchair (manual or electric) |
| ☐ | D. Limb prosthesis |
| ☐ | Z. None of the above were used |

### Item Rationale

#### Health-related Quality of Life

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

#### Planning for Care

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

### Steps for Assessment

1. Review the medical record for references to locomotion during the 7-day look-back period.

# G0600: Mobility Devices (cont.)

2. Talk with staff members who work with the resident as well as family/significant others about devices the resident used for mobility during the look-back period.
3. Observe the resident during locomotion.

## Coding Instructions

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

- Check G0600A, cane/crutch: if the resident used a cane or crutch, including single prong, tripod, quad cane, etc.
- Check G0600B, walker: if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with/without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.
- Check G0600C, wheelchair (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person.
- Check G0600D, limb prosthesis: if the resident used an artificial limb to replace a missing extremity.
- Check G0600Z, none of the above: if the resident used none of the mobility devices listed in G0600 or locomotion did not occur during the look-back period.

## Examples

1. The resident uses a quad cane daily to walk in the room and on the unit. The resident uses a standard push wheelchair that she self-propels when leaving the unit due to her issues with endurance.

   Coding: G0600A, use of cane/crutch, and G0600C, wheelchair, would be checked.

   Rationale: The resident uses a quad cane in her room and on the unit and a wheelchair off the unit.

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

   Coding: G0600D, limb prosthesis, would be checked.

   Rationale: The resident uses a leg prosthesis for ambulating.

# G0900: Functional Rehabilitation Potential

*Complete only on OBRA Admission Assessment (A0310A = 1)*

| G0900. Functional Rehabilitation Potential<br>Complete only if A0310A = 01 | |
|---|---|
| Enter Code ☐ | **A. Resident believes he or she is capable of increased independence** in at least some ADLs<br>0. **No**<br>1. **Yes**<br>9. **Unable to determine** |
| Enter Code ☐ | **B. Direct care staff believe resident is capable of increased independence** in at least some ADLs<br>0. **No**<br>1. **Yes** |

## Item Rationale

### Health-related Quality of Life

- Attaining and maintaining independence is important to an individual's feelings of autonomy and self-worth.
- Independence is also important to health status, as decline in function can trigger all of the complications of immobility, depression, and social isolation.

### Planning for Care

- Beliefs held by the resident and staff that the resident has the capacity for greater independence and involvement in self-care in at least some ADL areas may be important clues to assist in setting goals.
- Even if highly independent in an activity, the resident or staff may believe the resident can gain more independence (e.g., walk longer distances, shower independently).
- Disagreement between staff beliefs and resident beliefs should be explored by the interdisciplinary team.

## Steps for Assessment: Interview Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Ask if the resident thinks he or she could be more self-sufficient given more time.
2. Listen to and record what the resident believes, even if it appears unrealistic.
   - It is sometimes helpful to have a conversation with the resident that helps him/her break down this question. For example, you might ask the resident what types of things staff assist him with and how much of those activities the staff do for the resident. Then ask the resident, "Do you think that you could get to a point where you do more or all of the activity yourself?"

## Coding Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

- Code 0, no: if the resident indicates that he or she believes he or she will probably stay the same and continue with his or her current needs for assistance.

# G0900: Functional Rehabilitation Potential (cont.)

- Code 1, yes: if the resident indicates that he or she thinks he or she can improve. Code even if the resident's expectation appears unrealistic.
- Code 9, unable to determine: if the resident cannot indicate any beliefs about his or her functional rehabilitation potential.

## Example for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Mr. N. is cognitively impaired and receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff are not looking.

   Coding: G0900A would be coded 1, yes.
   Rationale: The resident believes he is capable of increased independence.

## Steps for Assessment for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. Discuss in interdisciplinary team meeting.
2. Ask staff who routinely care for or work with the resident if they think he or she is capable of greater independence in at least some ADLs.

## Coding Instructions for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

- Code 0, no: if staff believe the resident probably will stay the same and continue with current needs for assistance. Also **code 0** if staff believe the resident is likely to experience a decrease in his or her capacity for ADL care performance.
- Code 1, yes: if staff believe the resident can gain greater independence in ADLs or if staff indicate they are not sure about the potential for improvement, because that indicates some potential for improvement.

## Example for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. The nurse assistant who totally feeds Mrs. W. has noticed in the past week that Mrs. W. has made several attempts to pick up finger foods. She believes Mrs. W. could become more independent in eating if she received close supervision and cueing in a small group for restorative care in eating.

   Coding: G0900B would be coded 1, yes.
   Rationale: Based upon observation of the resident, the nurse assistant believes Mrs. W. is capable of increased independence.