Admission Assessment

Section GG: Functional Abilities and Goals (Select Items from the Admission Assessment)

GG0130A. Eating

- **Admission Performance Coding:** 88, Not attempted due to medical condition or safety concerns
- **Rationale:** Mrs. S was NPO (nothing by mouth) and receiving nutrition via gastrostomy tube (G-tube) at admission.

- **Discharge Goal:** 06, Independent
- **Rationale:** It is anticipated that oral nutrition will be reintroduced during the patient's post-acute care (PAC) stay, with the goal of her eating and drinking without any type of assistance by discharge.

GG0130B. Oral hygiene

- **Admission Performance Coding:** 05, Setup or clean-up assistance
- **Rationale:** Mrs. S brushes her teeth once a helper sets up her bedside table with her oral hygiene items and puts them away after she completes the activity.

- **Discharge Goal:** 06, Independent
- **Rationale:** It is anticipated that Mrs. S will not need any type of assistance with oral hygiene by discharge.

GG0130C. Toileting hygiene

- **Admission Performance Coding:** 04, Supervision or touching assistance
- **Rationale:** Mrs. S requires steadying assistance from one helper while she stands and adjusts her underwear and slacks. After she finishes voiding on the commode, she wipes herself and adjusts her underwear and slacks with contact guard assistance from a helper.

- **Discharge Goal**: 06, Independent
- **Rationale:** The occupational therapist anticipates that Mrs. S will not need any type of assistance from a helper with toilet hygiene by discharge.

GG0170F. Toilet transfer

- **Admission Performance Coding:** 03, Partial/moderate assistance
- **Rationale:** Mrs. S required the assistance of one helper providing less than half of the effort to transfer on and off the bedside commode.

- **Discharge Goal:** 06, Independent

- **Rationale:** The occupational therapist anticipates that Mrs. S will not require any type of assistance to perform toilet transfers using a standard toilet with raised toilet seat by discharge.

GG1070I. Walk 10 feet

- **Admission Performance Coding:** 03, Partial/moderate assistance
- **Rationale:** Mrs. S walks 10 feet with a rollator walker and the assistance of one helper providing less than half the effort. The use of assistive devices to complete an activity should not affect the coding of an activity.

- **Discharge Goal:** 04, Supervision or touching assistance
- **Rationale:** The physical therapist anticipated that the patient will walk 10 feet with a helper providing supervision assistance, using a rollator walker.

GG0170J. Walk 50 feet with two turns

- **Admission Performance Coding:** 88, Not attempted due to medical condition or safety concerns
- **Rationale:** This activity was not performed at admission due to the patient's fatigue and decreased endurance.

- **Discharge Goal:** 04, Supervision or touching assistance
- **Rationale:** Based on her prior mobility status, comorbidities, current functional performance, and motivation to improve, the physical therapist anticipates that Mrs. S will require contact guard assistance when walking 50 feet and making two turns by discharge using a rollator walker.

GG0170K. Walk 150 feet

- **Admission Performance Coding:** 09, Not applicable
- **Rationale:** This activity was not attempted during the 3-day assessment period and Mrs. S was not walking 150 feet prior to her current injury.

- **Discharge Goal:** 09, Not applicable
- **Rationale:** The physical therapist does not expect Mrs. S to perform this activity by discharge. She could not perform the activity prior to her current injury. The maximum distance walked by the patient prior to her current illness was up to 60 feet. Therefore, this activity goal is not applicable.

GG0170Q1. Does the patient use a wheelchair and/or scooter?

- **Coding:** 1, Yes
- **Rationale:** The patient uses a manual wheelchair for self-mobilizing on the unit and during the therapy evaluation.

GG0170R. Wheel 50 feet with two turns

- **Admission Performance Coding:** 02, Substantial/maximal assistance
- **Rationale:** Once seated in her manual wheelchair, Mrs. S propels herself 20 feet and requires some assistance to complete a turn and then requires a helper to mobilize her for 30 feet to complete the activity.

- **Discharge Goal:** 06, Independent
- **Rationale:** The physical therapist anticipates that Mrs. S will increase her level of endurance and complete self-mobilizing 50 feet in a manual wheelchair with two turns, without any type of assistance at discharge.

GG0170RR1: Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual
- **Rationale:** Mrs. S uses a manual wheelchair to self-mobilize.

GG0170S. Wheel 150 feet

- **Admission Performance Coding:** 02, Substantial/maximal assistance
- **Rationale:** After propelling herself 20 feet, Mrs. S becomes fatigued and a helper must propel her the remaining 130 feet distance to complete this activity.

- **Discharge Goal:** 02, Substantial/maximal assistance.
- **Rationale:** The physical therapist anticipates that beyond approximately 70 feet, a helper will propel Mrs. S for the remaining distance to complete this activity, based on her prior level of function.

GG0170SS1. Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual
- **Rationale:** Mrs. S uses a manual wheelchair to self-mobilize.

Section M: Skin Conditions (Admission Assessment)

M0210. Unhealed Pressure Ulcers/Injuries

- **Coding**: 1. Yes *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*
- **Rationale:** Upon admission to the PAC setting, Mrs. S has a pressure ulcer on her coccyx and a deep tissue injury (DTI) on her right lateral malleolus.

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- **Coding:**
  - M0300A1. Stage 1: **Code as 0**
  - M0300B1. Stage 2: **Code as 0**
  - M0300C1. Stage 3: **Code as 0**
  - M0300D1. Stage 4: **Code as 1**
  - M0300E1. Unstageable: Non-removable dressing/device: **Code as 0**
  - M0300F1. Unstageable: Slough and/or eschar: **Code as 0**
  - M0300G1. Unstageable: Deep tissue injury: **Code as 1**
- **Rationale:**
  - Upon admission to the PAC setting, Mrs. S has a pressure ulcer on her coccyx and a DTI on her right lateral malleolus. To accurately stage these wounds, the nurse reviews the history of these pressure ulcers in the patient's medical record.
  - Although the coccyx pressure ulcer has evidence of improvement and decrease in size upon PAC admission assessment, the acute care medical record classified it as a Stage 4. Therefore, it should continue to be classified at that numerical stage until healed.
  - The pressure ulcer on the right lateral malleolus is assessed as a DTI. This is confirmed upon review of the patient's acute care medical record.
  - The surgical site would not be coded in M0300 as it is not a pressure ulcer or injury. It is a surgical wound.

Section N: Medications (Admission Assessment)

N2001. Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

- **Coding:** 1. Yes – Issues found during review
- **Rationale:** The pharmacist identified that two different doses of the same medication to address mild pain were ordered. The combined dosage could exceed the maximum daily dosage for ibuprofen. The pharmacist considered this duplicate therapy a clinically significant medication issue.

N2003. Medication Follow-Up: Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

- **Coding:** 1. Yes
- **Rationale:** On the day of admission, the pharmacist identified a significant medication issue and contacted the admitting physician and left a message to discuss the medication orders. One hour later, the admitting physician returned the pharmacist's phone call to clarify and change the order. That evening, the charge nurse noted and implemented the order.

Discharge Assessment

Section GG: Functional Abilities and Goals (Select Items from the Discharge Assessment)

GG0130A. Eating

- **Discharge Performance Coding:** 06, Independent
- **Rationale:** Mrs. S self-feeds and drink liquids without assistance. She also requires additional nutrition with supplemental G-tube feedings. She opens containers and uses utensils and a cup/glass to self-feed and drink liquids without any assistance. Tube-feeding is not considered when coding GG0130A. Eating activity.

GG0130B. Oral hygiene

- **Discharge Performance Coding:** 06, Independent
- **Rationale:** Mrs. S completes all tasks included in the oral hygiene activity without any type of assistance.

GG0130C. Toileting hygiene

- **Discharge Performance Coding:** 06, Independent
- **Rationale:** Mrs. S manages her toilet hygiene without any type of assistance.

GG0170F. Toilet transfer

- **Discharge Performance Coding:** 06, Independent
- **Rationale:** Mrs. S completes this activity without any type of assistance.

GG0170I. Walk 10 feet

- **Discharge Performance Coding:** 04, Supervision or touching assistance
- **Rationale**: Mrs. S walks 10 feet using a rollator walker with supervision from one helper. The use of assistive devices to complete an activity should not affect the coding of an activity.

GG0170J. Walk 50 feet with two turns

- **Discharge Performance Coding:** 04, Supervision or touching assistance
- **Rationale:** Mrs. S walks 50 feet with two turns using a rollator walker and contact guard assistance. The use of assistive devices to complete an activity should not affect the coding of an activity.

GG0170K. Walk 150 feet

- **Discharge Performance Coding:** 09, Not applicable
- **Rationale:** This activity was not attempted and Mrs. S was not walking 150 feet prior to her current injury.

GG0170Q3. Does the patient use a wheelchair and/or scooter?

- **Coding:** 1, Yes
- **Rationale:** Mrs. S uses a manual wheelchair.

GG0170R. Wheel 50 feet with two turns

- **Discharge Performance Coding:** 06, Independent
- **Rationale:** Mrs. S wheels herself approximately 60 feet and completes two turns without any type of assistance.

GG0170RR3: Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual
- **Rationale:** Mrs. S used a manual wheelchair.

GG0170S: Wheel 150 feet

- **Discharge Performance Coding:** 02, Substantial/maximal assistance
- **Rationale:** Mrs. S wheels herself 60 feet, which is nearly her prior level of function. A helper is needed to propel her wheelchair the remaining distance of the 150 feet. The helper does more than half of the effort to complete this activity.

GG0170SS3: Indicate the type of wheelchair or scooter used

- **Coding:** 1, Manual
- **Rationale:** Mrs. S used a manual wheelchair.

Section M: Skin Conditions (Discharge Assessment)

M0210. Unhealed Pressure Ulcers/Injuries

- **Coding**: 1. Yes *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*
- **Rationale:** At discharge, Mrs. S has one unstageable pressure ulcer on her right lateral malleolus.

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- M0300A1. Stage 1: **Code as 0**
- M0300B1. Stage 2: **Code as 0**
  M0300B2. Number of **these** Stage 2 pressure ulcers that were present upon admission: **Skip**
- M0300C1. Stage 3: **Code as 0**
  M0300C2. Number of **these** Stage 3 pressure ulcers that were present upon admission: **Skip**
- M0300D1. Stage 4: **Code as 0**
  M0300D2. Number of **these** Stage 4 pressure ulcers that were present upon admission: **Skip**
- M0300E1. Unstageable – Non-removable dressing/device: **Code as 0**
  M0300E2. Number of **these** unstageable pressure ulcers/injuries that were present upon admission: **Skip**
- M0300F1. Unstageable – Slough and/or eschar: **Code as 1**
  M0300F2. Number of **these** unstageable pressure ulcers that were present upon admission: **Code as 0**
- M0300G1. Unstageable – DTI: **Code as 0**
  M0300G2**.** Number of **these** unstageable pressure injuries that were present upon admission: **Skip**

Rationale:

- Mrs. S has an unstageable pressure ulcer due to slough and/or eschar on her right lateral malleolus. This pressure ulcer was identified as a DTI at admission. During the patient's PAC stay, it presented as a Stage 4. However, at discharge, slough completely covered this pressure ulcer, preventing visualization of the wound bed. Therefore, it is considered not present on admission.

- The Stage 4 pressure ulcer that was on the coccyx has closed and would not be coded in M0300 on the Discharge Assessment.

Section N. Medications (Discharge Assessment)

N2005. Medication Intervention: Did the facility contact and complete a physician's (or physician-designee's) prescribed/recommended actions by midnight of the next calendar day each time that potential clinically significant medication issues were identified since the admission?

- **Coding:** 1. Yes
- **Rationale:** The clinically significant medication issue identified by the pharmacist on the day of admission was communicated to the physician, and the physician's recommended actions were completed by midnight of the next calendar day. On day 10, Mrs. S had a clinically significant medication issue related to hydrocodone. A physician was immediately contacted, and the physician's recommended actions of administering naloxone and discontinuing hydrocodone were completed by midnight of the next calendar day. No other clinically significant medication issues were identified during the patient's PAC stay.