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

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

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

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

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

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

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

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

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

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

GG0130: Self-Care (OBRA/Interim)

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

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

Coding:

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

Activities may be completed with or without assistive devices.

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

If activity was not attempted, code reason:

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

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

GG0130: Self-Care (cont.)

Item Rationale

Health-related Quality of Life

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

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

Planning for Care

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

GG0130: Self-Care (cont.)

Steps for Assessment

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

DEFINITIONS

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

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

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

GG0130: Self-Care (cont.)

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

Coding Instructions

- When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by *them*self with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).
- **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
    - *Code 04, Supervision or touching assistance: if the resident requires only verbal cueing to complete the activity safely.*
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

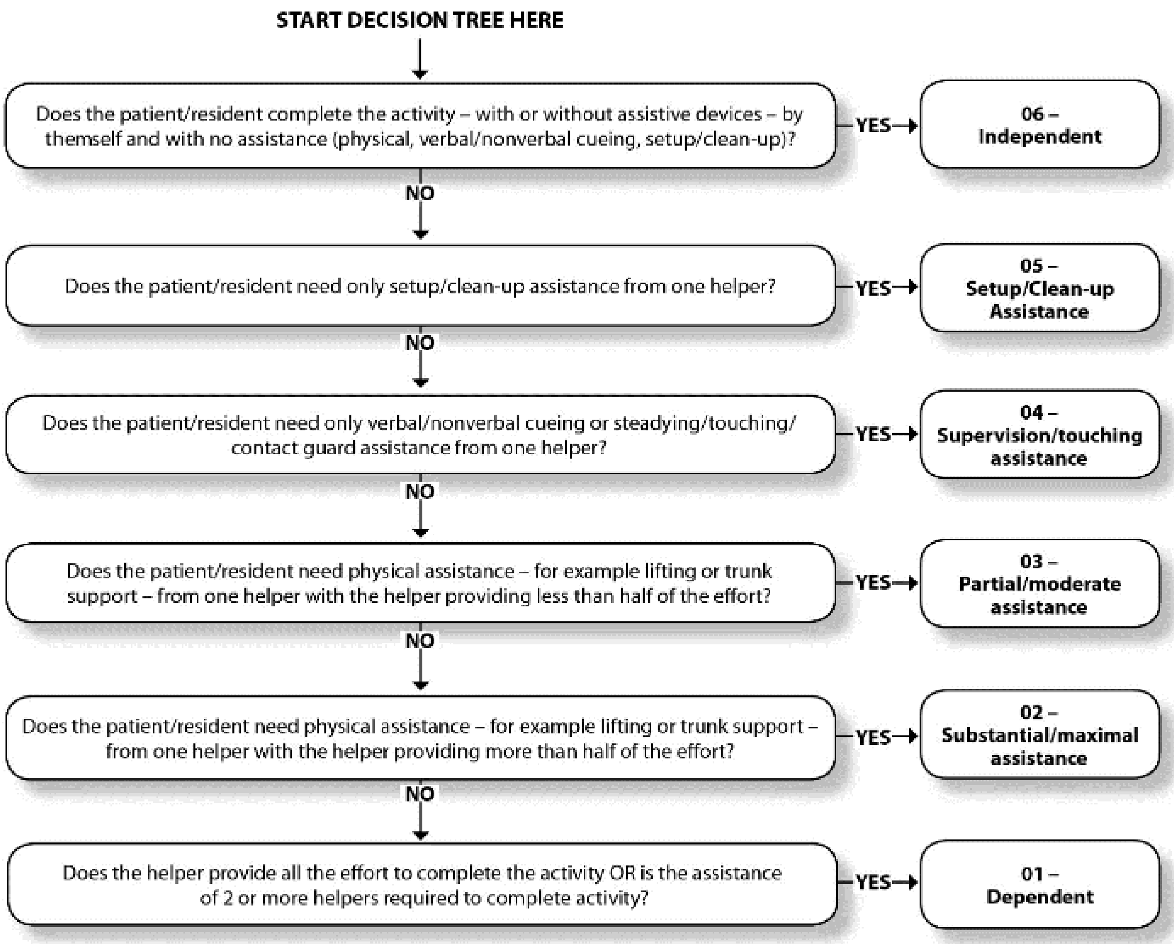
GG0130: Self-Care (cont.)

- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
  - *Code 01, Dependent: if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance.*
  - *Code 01, Dependent: if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed).*
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.

GG0130: Self-Care (cont.)

Decision Tree

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



GG0130: Self-Care (cont.)

Assessment Period

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

GG0130: Self-Care (cont.)

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

Coding Tips

General Coding Tips

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

GG0130: Self-Care (cont.)

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

Tips for Coding the Resident's Usual Performance

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

GG0130: Self-Care (cont.)

Coding Tips for GG0130A, Eating

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

Examples for Coding Performance

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

GG0130: Self-Care (cont.)

Examples for GG0130A, Eating

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

   Coding: GG0130A would be coded 03, Partial/moderate assistance.

   Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

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

   Coding: GG0130A would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

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

   Coding: GG0130A would be coded 05, Setup or clean-up assistance.

   Rationale: The helper provided setup assistance prior to the eating activity.

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

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

   Rationale: *Resident* H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

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

   Coding: GG0130A would be coded 88, Not attempted due to medical condition or safety concerns.

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

GG0130: Self-Care (cont.)

Coding Tip*s* for GG0130B, Oral hygiene

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

Examples for GG0130B, Oral hygiene

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

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

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

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

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

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

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

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

GG0130: Self-Care (cont.)

Coding Tips for GG0130C, Toileting hygiene

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

Examples for GG0130C, Toileting hygiene

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

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

GG0130: Self-Care (cont.)

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

   Coding: GG0130C would be coded 01, Dependent.

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

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

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

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

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

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

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

Coding Tips for GG0130E, Shower/bathe self

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

GG0130: Self-Care (cont.)

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

Examples for GG0130E, Shower/bathe self

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

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

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

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

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

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

GG0130: Self-Care (cont.)

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

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

GG0130: Self-Care (cont.)

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

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

Examples for GG0130F, Upper body dressing

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

   Coding: GG0130F would be coded 05, Setup or clean-up assistance.
   Rationale: *Resident* Y dresses and undresses *their* upper body and requires a helper only to retrieve and put away *their* clothing, that is, setting up the clothing for *their* use. The description refers to *Resident* Y as "independent" (when removing clothes), but *they* need setup assistance, so *they are* not independent with regard to the entire activity of upper body dressing.

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

   Coding: GG0130F would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides assistance with threading *Resident* Z's arms into *their* bra and hooking and unhooking *their* bra clasps and assistance with removing one sleeve of the sweatshirt. *Resident* Z performs more than half of the effort.

GG0130: Self-Care (cont.)

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

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

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

Examples for GG0130G, Lower body dressing

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

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

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

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

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

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

GG0130: Self-Care (cont.)

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

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

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

Examples for GG0130H, Putting on/taking off footwear

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

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

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

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

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

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

GG0130: Self-Care (cont.)

Coding Tips for GG0130I, Personal hygiene

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

Examples for GG0130I, Personal hygiene

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

   Coding: *GG01301 would be coded 04, Supervision or touching assistance.*

   Rationale: *A certified nursing assistant placed grooming devices at sink for the resident's use and provided cueing during the observation period.*

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

   Coding: *GG0130I would be coded 02, Substantial/moderate assistance.*

   Rationale: *Resident J was unable to complete their personal hygiene and required a certified nursing assistant to complete their personal hygiene tasks during the assessment period. The certified nursing assistant provided more than half the effort to complete the personal hygiene tasks.*

GG0130: Self-Care (cont.)

Examples of Probing Conversations with Staff

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GG0130: Self-Care (cont.)

Discharge Goals: Coding Tips

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

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

Discharge Goal: Coding Examples

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

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

GG0130: Self-Care (cont.)

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

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

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

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

GG0130: Self-Care (cont.)

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

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

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

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

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