**Agency Nursing Assistant Competency Checklist – Section GG Coding**

*State logo added here. If not, delete text box.*

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Skill Area** | | **Evaluation** | | **Method of Evaluation**  D = Skills Demonstration  O = Performance Observation | | **Recommendations** |
| --- | --- | --- | --- | --- | --- | --- |
| **Competency** | **Needs Additional Training** |
| **D** | **O** |  |
| **Competency** | Identify location of computer stations designated to nursing assistants. |  |  |  |  |  |
| Demonstrates computer log-in  User ID and password is assigned |  |  |  |  |  |
| Identifies the residents assigned to complete section GG |  |  |  |  |  |
| Described the shift expectations on completing section GG |  |  |  |  |  |
| States current experience in completing section GG. |  |  |  |  |  |
| Agency: Request training records for the nursing assistant |  |  |  |  |  |
| Verbalizes facility contact to assist with questions on documentation: ***Assign an experienced nursing assistant*** |  |  |  |  |  |
| Reviews facility agency orientation guide on GG documentation. |  |  |  |  |  |
| Records GG tasks, self-care, and mobility tasks before the end of shift |  |  |  |  |  |
| Reports off to the licensed nurse the completion of the required documentation. |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**References and Resources**

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities. <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual. Version 1.18.11, October 2023: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>

**\*I certify that I have received orientation in the above-mentioned areas.**

**\*Employee:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Initials**  **Signature**  **Date**

**Evaluator/Trainer:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Initials Signature Date**

***(PLACE IN EMPLOYMENT FILE)***