**Licensed Nurse 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 DemonstrationO = Performance Observation | **Recommendations** |
| --- | --- | --- | --- |
| **Competency** | **Needs Additional Training** |
| **D** | **O** |  |
| **Competency** | Reviews and signs job description at the time of hire and with annual review.  |  |  |  |  |  |
| Demonstrates computer log-in User ID and password |  |  |  |  |  |
| Completed GG training in on-boarding education during orientation.  |  |  |  |  |  |
| Demonstrated ability to access GG documentation and assigned assessments.  |  |  |  |  |  |
| Completed the CMS training video’s |  |  |  |  |  |
| Identifies the residents assigned to complete section GG |  |  |  |  |  |
| States the frequency of section GG coding based on current policy. * Day shift
* Evening shift
* Night shift
 |  |  |  |  |  |
| Lists the self-care categories  |  |  |  |  |  |
| Completes the on-line GG training as assigned.  |  |  |  |  |  |
| States three criteria to determine usual performance  |  |  |  |  |  |
| Records self-care tasks in electronic or paper documentation each time a task is completed. **Example: Eating (records after each meal)** |  |  |  |  |  |
| Recalls the components of toileting hygiene.  |  |  |  |  |  |
| States the categories included in upper body dressing |  |  |  |  |  |
| States the categories included in lower body dressing |  |  |  |  |  |
|  | States the categories included in footwear.  |  |  |  |  |  |
|  | Identifies the devices that the resident utilized for mobility  |  |  |  |  |  |
|  | Relate the facility process to correct coding errors in section GG |  |  |  |  |  |
|  | State the appropriate code when a resident is transferred via full body mechanical lift.  |  |  |  |  |  |
|  | Relates the facility process to correct coding errors in section GG |  |  |  |  |  |
|  | Describes two reasons section GG must be accurate and completed on the days assigned.  |  |  |  |  |  |
|  | Demonstrated ability to access therapy notes, assessments and plan of care.  |  |  |  |  |  |
|  | Successfully completed the GG post-test with a score of 80%. |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**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)***