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

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

| **Skill Area** | **Evaluation** | **Method of Evaluation**D = Skills DemonstrationO = Performance Observation | **Recommendations** |
| --- | --- | --- | --- |
| **Competency** | **Needs Additional Training** |
| **D** | **O** |  |
| **Competency** | Identify location of computer stations designated to nursing assistants.  |  |  |  |  |  |
| Completed required computer-based training on section GG  |  |  |  |  |  |
| Completed GG training in on-boarding education.  |  |  |  |  |  |
| Demonstrates computer log-in User ID and password |  |  |  |  |  |
| Identifies the residents assigned to complete section GG |  |  |  |  |  |
| Assigned a nursing assistant mentor |  |  |  |  |  |
| States the frequency of section GG coding.* Day shift
* Evening shift
* Night shift
 |  |  |  |  |  |
| Lists the self-care categories  |  |  |  |  |  |
| Lists the mobility categories  |  |  |  |  |  |
| 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.  |  |  |  |  |  |
|  | Name the individual that will assist you with questions on the completion of section GG.  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**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:**

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

**Evaluator/Trainer:**

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

**Initials Signature Date**

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