

Creating Documentation for Section GG

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Inter-disciplinary Approach

Functionality of the documentation is assuming a full inter-disciplinary team approach. However, each facility will have its own policies reflecting who is responsible for this documentation. You will need to be aware of such policies when completing the setup.

1. Individuals from within multiple disciplines can enter performance baseline observations for each shift during the three-day observation periods.
2. An oversight person from each of those disciplines can review the information and establish the performance baseline and, for the 5-day assessment, the discharge goal(s) for their discipline. For example, nursing oversight may review CNA and nursing (LPN or RN) data for all three shifts during the period and then establish the nursing baseline with an appropriate goal(s). The therapy oversight person may do the same for all of the therapists and therapy aides.
3. Prior to completing the MDS, the MDS coordinator (or a team meeting), can review each discipline's baseline observations. Interviews can help reconcile any discrepancies between disciplines. The final baselines and goal(s) can be recorded along with notes to explain the conclusions.

Setup

You must decide whether you wish CNAs to document the usual performance they see during their shifts over the first three days of admission/readmission or the last three days prior to a scheduled discharge.

Resident Observations 3.0 – Utilities – ResObs Security

You must get everyone out of ResObs for a few minutes before you can make changes to the system. Once everyone is out, go to the fourth tab, **MDS GG**. You will need to decide the type of residents that you want to track. This will be facility specific and up to your individual policies. You have three options:

1. Pop the option for only those who are traditional Medicare.
2. Pop the option for all that have traditional Medicare as well as those on Replacement plans. Some facilities are doing this so that in the event they initially believe they are on a replacement and later discover they actually were traditional Medicare, they have the information available to complete the assessments.
3. Pop the option for everyone.

You will also need to decide whether you are going to turn on this option for the CNAs. Answer the last question according to how you wish to handle this.

Security	Shift Times	Other	MDS GG
<p>For Admissions/Readmissions and for Planned Discharges, indicate which insurances you want Section GG tracked for the MDS.</p> <p>Do Section GG Tracking for: <input type="text" value="1"/></p> <p> 1 = Medicare A only (required) 2 = Medicare A and Medicare Replacement Plans 3 = Everyone </p> <p>Enter a "Y" if CNA input for section GG is to be turned on: <input type="text" value="Y"/></p>			
<input type="button" value="Cancel"/>		<input type="button" value="Return"/>	

CNA Data Entry

Security has been set to Y(es) for CNA input (see above).

If you are within three days of an admission or readmission census transaction or within three days of a scheduled discharge (see Entering a Planned Discharge Date), when CNAs complete their normal **SHIFT END** observations, they will be presented with a new screen where they may enter their Performance observations.

Their screen will have three tabs – one for Self-care items and two for the Mobility items. They will click on the first, Eating.

Self-care	Mobility 1	Mobility 2
Resident: BOUT - 01/402 Date: 04/17/2017 Time: 14:29		
<div>Eating</div>	The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.	
<div>Oral Hygiene</div>	The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]	
<div>Toilet Hygiene</div>	The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.	
<div>Cancel</div>	<div>Clear Input</div>	<div>Next Page</div> <div>Save Observations</div>

They will have buttons for the various levels of care. Each button gives the number and word used to describe the amount of assistance per the MDS. Next to each button is a clue for that level of care. CNAs do NOT have the option of using 09 Not Applicable or 88 Not Attempted due to Medical Condition or Safety Concerns. They do, however, have a button for DID NOT HAPPEN THIS SHIFT. This is so the oversight person knows the aide did not just forget to record this observation.

Resident's Usual Performance: 3OUT - 01/402 for EATING	
Select the button that best describes how much effort the RESIDENT did and how much help you provided.	
<div>01 Totally Dependent</div>	<div>05 Just Set-up or Clean-up help</div>
<div>02 Required lots of help</div>	<div>06 Needs no help - Independent</div>
<div>03 Required some help</div>	<div>07 Resident Refused</div>
<div>04 Just Supervision or Touching Assistance</div>	<div>Did not happen this shift</div>
<div>Cancel</div>	<div>Return</div>

The CNA will click the button for the correct amount of assistance. That will return them to the list of tasks where they can select the next item, i.e. Oral Hygiene. They will continue until they have recorded a performance observation or "Did not happen for this shift" for each section. When finished, they will select SAVE OBSERVATIONS.

Other Staff Observations

LPN, RN, therapists, social workers, dietary, activities, etc. – however you define your interdisciplinary team for Section GG documentation, can also record baseline observations for each of the three days. They can do so through **Resident Observations – Nursing Data Entry**.

Selection of the resident will determine which, if any, of the Section GG buttons are available to you. If you are not within the observation window, then none of the buttons will be active.

- **Section GG Tracking** – allows you to record the baseline performance observations for your shift.
- **Final Discipline (Re)Admission GG Decisions** – this allows you to see all of the observations over the three-day period since the (re)admission transaction for YOUR discipline. You can review and make a final decision for the baseline performance at admission and the discharge goal(s) for YOUR discipline.
- **Final Discipline GG Decisions** – this option allows you to see all of YOUR discipline's observations over the three days prior to the planned discharge. Your discipline can review and enter the final decision for the baseline performance at discharge.

In the above illustration, Ms. Georges is within the first three days since her admission. The system is open to allow tracking of the baseline performance and also for the disciplines to set the final decisions for the 5-day assessment. There is no planned discharge within the next three days so the Final Decisions for the discharge are grayed out, inactive.

If the staff member does not have a discipline that is identifiable by the system, you will first see a list of disciplines to select from. We do our best to match what we can, but some facilities put the job title in the DISCIPLINE field in the password module. That can make matching disciplines more difficult. If that happens, simply select your discipline from the list so that you can proceed.

Section GG Discipline

Your discipline could not be found. Please select the correct discipline for this GG shift record.

NURSING

NUTRITION

THERAPY

ACTIVITIES

SOCIAL SERVICES

OTHER

Cancel

Return

Section GG Tracking

This button will display similar screens to those the CNAs see during their shift-end routine. It will have three tabs – one for Self-care items and two for the Mobility items. Select the first item, Eating.

Each button gives the number and word used to describe the amount of assistance per the MDS. Next to each button is a clue for that level of care. Notice that now the choices for 09 Not Applicable and 88 Not Attempted are available for selection.

Resident's Usual Performance: GEORGES - 02/008 for EATING

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.

<div style="border: 1px solid black; background-color: #FFDADA; padding: 5px; margin-bottom: 5px;"> 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. </div> <div style="border: 1px solid black; background-color: #FFFFE0; padding: 5px; margin-bottom: 5px;"> 02 Substantial/Maximal Assistance Helper does MORE THAN HALF the effort. Helper lifts or holds trunks or limbs and provides more than half the effort. </div> <div style="border: 1px solid black; background-color: #E0FFFF; padding: 5px; margin-bottom: 5px;"> 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. </div> <div style="border: 1px solid black; background-color: #FFDADA; padding: 5px;"> 04 Supervision or Touching Assistance Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently. </div>	<div style="border: 1px solid black; background-color: #ADD8E6; padding: 5px; margin-bottom: 5px;"> 05 Set-up or Clean-up Assistance Helper SETS UP or CLEANS UP. Resident completes the activity. Helper assists only prior to or following the activity. </div> <div style="border: 1px solid black; background-color: #FFDADA; padding: 5px; margin-bottom: 5px;"> 06 Independent Resident completes the activity by him/herself with no assistance from a helper. </div> <div style="border: 1px solid black; background-color: #D8BFD8; padding: 5px; margin-bottom: 5px;"> 07 Resident Refused </div> <div style="border: 1px solid black; background-color: #00FF00; padding: 5px; margin-bottom: 5px;"> 09 Not Applicable </div> <div style="border: 1px solid black; background-color: #FFFFE0; padding: 5px;"> 88 Not Attempted Not Attempted Due to Medical Condition or Safety Concerns </div>
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Staff will click the button for the correct amount of assistance. That will return them to the list of tasks where they can select the next item, i.e. Oral Hygiene. They will continue until they have recorded a performance observation for each section they have responsibility for. When finished, they will select SAVE OBSERVATIONS.

Final Discipline Decisions

At the end of the three-day observation or at the time of therapy interventions, each discipline will want to review their data entries and make a final determination as to baseline performance and, in the case of the admission, they will want to establish at least one goal.

Resident Observations – Nursing Data Entry

Select the resident. You will use one of the final decision buttons depending on whether this is the admission side of the stay or the discharge side.

The illustrations below are based on the (Re)Admission screens. Here you will determine both the baseline performance and at least one goal. The Discharge screens look similar except you will not be specifying a goal.

The oversight person for the department of nursing will see all of the CNA entries (CNA? = Y in column 2) as well as any LPN, RN, etc. observations that were entered over the three-day period. The --- (see Oral, row 1) indicates that the CNA reported that the task did not occur during the shift.

[illegible]

After evaluating all of the observations and any Progress Notes, the nursing department (in this illustration) can enter their determination for the baseline performance/goal(s) into the boxes at the bottom of the corresponding column. Move from tab to tab (Self Care to Positions to Transfer and so on) until baseline performance has been assigned according to your facility's policy. If responsibility for specific items are split between disciplines, your discipline may only score some of the items. Each discipline will review and score as appropriate. If no goal is being set for an item, you may enter a dash. Just remember, you need to specify at least one goal (performance can improve, decline, or stay the same).

The last tab, GOAL NOTES, shows a summary of the performance scores and the goal(s) you have assigned. It also has a place for the discipline to record the rationale for making the selection(s).

Section GG Data for NURSING		Resident: \ GEORGES - 02/008		Admission 04/17/2017	
Self Care	Positions	Transfer	Walk/Wheel	Goal Notes	
Usual Performance	Discharge Goal	Discipline Notes:			
Eating	05 / -	Resident reported needing assistance with placement of her walker in the bathroom so that she can turn for proper placement for moving on and off the toilet. With therapy we feel she will be strong enough when she discharges to return to that level of assistance.			
Oral Hygiene	05 / -				
Toilet Hygiene	04 / -				
Sit to Lying	03 / -				
Lying-Sitting, Side of Bed	03 / -				
Sit to Stand	03 / -				
Chair/ Chair-to-bed	03 / -				
Toilet Transfer	03 / 05				
Walk 50 ft with 2 Turns	04 / -				
Walk 150 ft	03 / -				
Wheel 50ft with 2 Turns	09 / -				
Wheel 150 ft	09 / -				

06=Independent
 05=Setup/Clean-up
 04=Supervision/touching

03=Partial/moderate
 02=Substantial/maximal
 01=Dependent

07=Resident Refused
 09=Not applicable
 88=Not attempted

Close

The Final Discipline GG Decisions for Discharge have screens identical to those above. The only difference is that the goal fields are inactive since goals are only established for the 5-day assessment.

Making Decisions for the MDS

The MDS Coordinator (or other responsible party) then will examine the information from the various disciplines and make the final determination as to what gets put on the MDS. This is done through the **Care Center**.

Display your resident and then click the MDS shortcut button on the right side of the window. On the left side of the pop-up menu window you will now have options to Finalize MDS (Re)Admit or Discharge GG. Which button is active will depend on the specific resident.

MDS3.0

OPTIONS

MDS3.0

CAA

Finalize MDS (Re)Admit GG

←

Set Discharge Date

Finalize MDS Discharge GG

←

Clear Discharge Date

REPORTS

Individual PPS Worksheet

MDS Comparison

Chart ADL History

Why Not?

Finished

The resident in our illustration has just been admitted so we need to finalize the admission performance baseline and the discharge goals. Both Nursing and Therapy entered observations, although each did not evaluate every item. We see the Discipline and the person (User) who made the discipline's final determination.

Section GG Data for Resident: **GEORGES - 02/008** Admission **04/17/2017**

Self Care	Positions	Transfer	Walk/Wheel	Disc Notes	MDS Notes
Discipline	User	Chair/Chair-to-bed	Goal	Toilet Transfer	Goal
THERAPY	PT	04	-	03	05
NURSING	P&NP	03	-	03	05

Enter Performance Score and Discharge Goals: / / / /

Previous Next

06=Independent 03=Partial/moderate 07=Resident Refused
 05=Setup/Clean-up 02=Substantial/maximal 09=Not applicable
 04=Supervision/touching 01=Dependent 88=Not attempted

Close

If both disciplines made the same observations, then this step should be fairly straight forward. However, since disciplines see residents at different times of the day and for different amounts of time, it is possible to have different observations. Above, on the transfer tab, you can see that Therapy scored this resident with a 04 for Chair/Chair-to-bed. Nursing scored this with a 03. You may wish to review notes or to interview staff members to get a clearer view of this resident's "usual" performance.

The Walk/Wheel tab (below) contains the additional questions asked on the MDS: "Does this resident walk?" and "Does this resident use a wheelchair/scooter?" If you answer the questions here, the information will pull forward into the MDS. Review the information you have and make a final determination for your MDS.

Section GG Data for Resident: **GEORGES - 02/008** Admission **04/17/2017**

Self Care	Positions	Transfer	Walk/Wheel		Disc Notes		MDS Notes		
Discipline	User	Walk 50	Goal	Walk 150	Goal	Wheel 50	Goal	Wheel 150	Goal
THERAPY	PT	04	05	88	-	09	-	09	-
NURSING	P&NP	04	-	03	-	09	-	09	-

Enter Performance Score and Discharge Goals: / /

Does this resident walk? 0-No, and walking goal is not clinically indicated
1-No, and walking goal is clinically indicated
2-Yes

Does this resident use a wheelchair/scooter? 0-No, 1-Yes

Wheel 50ft with 2 Turns / Wheel 150 ft /

What type? 1-Manual 2-Motorized

What type? 1-Manual 2-Motorized

06=Independent 03=Partial/moderate 07=Resident Refused
05=Setup/Clean-up 02=Substantial/maximal 09=Not applicable
04=Supervision/touching 01=Dependent 88=Not attempted

[Previous](#) [Next](#) [Close](#)

Notice that there is a DISC NOTES tab (shown below). This is the note where each discipline explained rationale for their scoring. The list of disciplines who participated will be on the left. When you highlight the discipline, you will see their notes on the right. In our example below, Therapy is highlighted and the corresponding therapy note is displayed on the right. To see the Nursing note, simply highlight that discipline.

Section GG Data for Resident: **GEORGES - 02/008** Admission **04/17/2017**

Self Care	Positions	Transfer	Walk/Wheel	Disc Notes	MDS Notes
<p>Discipline Notes for: THERAPY</p> <p>Ms. George reported (family confirmed) prior to hospitalization she was able to walk and toilet herself with only assistance in placing the walker. Her bathroom at home is fairly small so she needs assistance in placement of the walker in order to get herself in position to sit/stand on the toilet. We feel she will be strong enough to get herself on/off but will continue to need assistance in getting her walker into a useful position.</p>					

Discipline: **THERAPY**

[Previous](#) [Next](#) [Close](#)

The MDS NOTES tab allows this decision-maker (MDS coordinator or responsible person) to write his/her notes for the final rationale. In our example where there was a discrepancy in Transfer, you may have found upon interview, that Therapy was based upon a single observation prior to their intervention. However, Nursing was

able to make several observations over the course of the first two days (time prior to therapy intervention). Since this is supposed to reflect “Usual Performance”, you elected to accept the Nursing observations for this item.

This tab also summarizes the information that you will import into the MDS.

Section GG Data for Resident:		GEORGES - 02/008		Admission 04/17/2017	
Self Care	Positions	Transfer	Walk/Wheel	Disc Notes	MDS Notes
Usual Performance Eating 05 / - Oral Hygiene 05 / - Toilet Hygiene 04 / - Sit to Lying 03 / - Lying-Sitting, Side of Bed 03 / - Sit to Stand 03 / - Chair/ Chair-to-bed 03 / - Toilet Transfer 03 / 05		Discipline Notes: Upon interviewing both Therapy and Nursing and reading their Progress Notes for this period, I was able to determine that therapies observations were based upon a single encounter made prior to eval/treatment. Nursing observations spanned all three shifts for the same period. We were able to determine that the usual performance for transferring was 03			
Does this resident walk? 0-No, and walking goal is not clinically indicated 1-No, and walking goal is clinically indicated 2-Yes		Does this resident use a wheelchair/scooter? 0-No, 1-Yes			
Walk 50 ft with 2 Turns 04 / 05 Walk 150 ft 88 / -		Wheel 50ft with 2 Turns ^ / ^ Wheel 150 ft ^ / ^ What type? 1-Manual 2-Motorized			

Establishing a Discharge Date

This may be a planned physical discharge from the facility or the end of the Medicare stay. While the system can know the census transaction for the Admission and set up the three observation days for the 5-day assessment, it cannot know a future discharge date without your intervention.

Care Center – MDS button

You will see two buttons. One allows you to **Set a Discharge Date**. This will open the three-day window for tracking usual performance and for allowing each of the disciplines to make a determination. The second button will **Clear the Discharge Date**. If the planned discharge is canceled, using this button will close the observation window. Any information previously recorded will NOT be deleted.

If the planned discharge date changes, you can click the Set Discharge Date button a second time and simply update the information. If a planned discharge date has been entered into the system, you will see the information on the Resident's Care Center screen just above the MDS assessment information (shown below).

Note: As of now, 2017, if your Medicare A resident has a planned discharge to an acute care hospital (i.e. surgery), you do NOT need to collect this Section GG information. The discharge to a hospital assessment does require the end of Medicare A stay assessment (A0310H=1). However, it does not currently require completion of Section GG.

Screens for recording data and making decisions will look like those used above. The only difference is that you will only be working with the usual performance and NOT the discharge goals.

Reports

Resident Observations 3.0 – Analytics/Reports – Assessments

Discipline GG Tracking

This reports shows you the individual observations per discipline plus that discipline's final decisions.

Select the resident and you will see a list of census transaction dates and the discipline that recorded Section GG data entries. For the resident below, you can see that there are two census transactions. The bottom, or oldest,

[illegible]

The bottom two lines of data show an asterisk * next to the user name to indicate that this information was recorded by a CNA during the shift end process. The – in the last column indicates that those mobility points did not occur during their shift. The second line is a nursing staff member (LPN, RN) that recorded data using the Nursing Data Entry. The top line shows the Discipline's final decisions. If there are any notes associated with these decisions, they will be shown below the final decisions.

05/25/17

Section GG Tracking Report

For: LOUISA - 01/502A Date: 05/02/17 READMIT FROM HOSPITAL

Date	Discipline	User	Shift	Eating		Oral Hygiene		Toilet Hygiene		Sit to Lying		Lying to Sitting		Sit to Stand		Chair/ Chr-to-bed		Toilet Transfer		Walk 50ft w/ 2 turns		Walk 150 ft		Wheel 50ft w/ 2 turns		Wheel 150 ft	
				U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G	U.P.	G
05/05/17	NURSING Decisions			04	05	04	05	03	05	04	05	03	05	04	05	03	05	03	05	04	05	04	05	09	09	09	09
05/04/17	NURSING		D	05		04		03		04		03		04		03		03		04		04		09		09	
05/04/17	NURSING	*	D	03		03		03		05		03		04		04		03		04		04		--		--	
05/04/17	NURSING	/*	D	04		04		03		04		03		04		03		03		04		03		--		--	

Page 1

01 = Dependent
02 = Substantial/Maximal Assistance
03 = Partial/Moderate Assistance

04 = Supervision or Touching Assistance
05 = Set-up or Clean-up Assistance
06 = Independent

e 07 = Resident Refused
09 = Not Applicable
88 = Not Attempted

* by User name designates a CNA
For CNA records, all are same except:
"..." = Not Applicable/Not Attempted/Did not do that shift

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MDS Interface

If you have Resident Observations 3.0, you will now notice that the boxes for the Section GG questions have a blue ring around them. This indicates there is a link between these questions and data collected through the ResObs module.

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="text"/>	<input type="text"/>	B. Oral Hygiene: The ability to use suitable items to clean teeth. (Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.)
<input type="text"/>	<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.


While in any of the questions, press the F9 key. If the MDS coordinator, or other responsible person has indicated final decisions for usual admission performance, discharge goal and/or usual discharge performance through the Care Center, those observations will be listed for your review.

Below is an example of an admission final decision for a 5-day assessment. The Decision Date indicates the admission date. The first column corresponds to the “usual” performance at admission. The second column corresponds to the discharge goals. Remember that you must have at least one discharge goal.


		Decision Dates
GG0130. Self-Care		<input type="text" value="06/09/2017"/>
A. Eating	A. <input type="text" value="06"/> / <input type="text" value="06"/>	
B. Ora	B. <input type="text" value="06"/> / <input type="text" value="06"/>	
C. Toileting Hygiene	C. <input type="text" value="03"/> / <input type="text" value="-"/>	
GG0170. Mobility		
B. Sit to lying	B. <input type="text" value="03"/> / <input type="text" value="-"/>	
C. Lying to sitting on side of bed	C. <input type="text" value="03"/> / <input type="text" value="-"/>	
D. Sit to stand	D. <input type="text" value="03"/> / <input type="text" value="-"/>	
E. Chair/bed-to-chair transfer	E. <input type="text" value="03"/> / <input type="text" value="-"/>	
F. Toilet transfer	F. <input type="text" value="03"/> / <input type="text" value="-"/>	
H. Does the resident walk?	H. <input type="text" value="2"/>	
J. Walk 50 feet with two turns	J. <input type="text" value="03"/> / <input type="text" value="05"/>	
K. Walk 150 feet	K. <input type="text" value="03"/> / <input type="text" value="-"/>	
Q. Does the resident use a wheelchair/scooter	Q. <input type="text" value="0"/>	
R. Wheel 50 feet with two turns	R. <input type="text" value="A"/> / <input type="text" value="A"/>	
RR. Indicate the type of wheelchair/scooter used	RR. <input type="text" value="A"/>	
S. Wheel 150 feet	S. <input type="text" value="A"/> / <input type="text" value="A"/>	
SS. Indicate the type of wheelchair/scooter used	SS. <input type="text" value="A"/>	

Below is an example of a discharge final decision. The Decision Date corresponds to the discharge date. The column of data is the usual performance for the three day period prior to discharge.

GG0130. Self-Care		Decision Dates
A. Eating	A. 04	06/13/2017
B. Ora	B. 03	
C. Toileting Hygiene	C. 03	
GG0170. Mobility		
B. Sit to lying	B. 04	
C. Lying to sitting on side of bed	C. 04	
D. Sit to stand	D. 04	
E. Chair/bed-to-chair transfer	E. 06	
F. Toilet transfer	F. 06	
H. Does the resident walk?	H. 2	
J. Walk 50 feet with two turns	J. 06	
K. Walk 150 feet	K. 06	
Q. Does the resident use a wheelchair/scooter	Q. 0	
R. Wheel 50 feet with two turns	R. ^	
RR. Indicate the type of wheelchair/scooter used	RR. ^	
S. Wheel 150 feet	S. ^	
SS. Indicate the type of wheelchair/scooter used	SS. ^	



Cancel



Accept

After your review, press ACCEPT to fill in the MDS with these values. Press CANCEL if you need to do further research.

If this is a 5-day, discharge combination where you will need to complete both the admission performance, the discharge goals, and the discharge performance you will need to complete the F9 process twice – once in the admission portion and again in the discharge portion.