MDS Alert

RAI Compliance: Sidestep These Common Mistakes In Performing, Coding Task Segmentation

Otherwise, surveyors or your F1 may take you to task.

The best way to deal with red flags is to catch them before they end up at the top of the flagpole, calling attention to a potential inconsistency in your MDS coding or care.

For example, watch out for scenarios in which you're providing and coding task segmentation for a resident scored as a "4" for total dependence in his activities of daily living.

For one, "if a resident performs any subtask of an ADL, the person isn't totally dependent," says Steven Littlehale, MSN, RN, chief clinical officer for LTCQ Inc. in Lexington, MA. "This type of discrepancy" might cause your FI to assume you're upcoding the resident's ADLs, Littlehale cautions. From a care perspective, if a resident receives task segmentation coded at G7, "the assumption is that he's benefiting from it," adds Littlehale. And you are going to have a hard time justifying "continually checking task segmentation if a resident is totally dependent in all ADLs," he says.

Another potential discrepancy: If you're coding restorative nursing at P3--and not task segmentation at G7--take a closer look. Staff are either actually doing task segmentation or, if not, they should be assisting residents to become more independent. In providing restorative, "you should be breaking down instructions for the person," says **Mary Mondero, RN**, an MDS coordinator at Isabella Geriatric Center in New York City.

"Staff may be doing more task segmentation than they realize--for example, they don't just tell someone who has had a recent CVA, 'Dress yourself.' They break it down by saying 'here's a shirt, please put your arm in the sleeve,'" observes **Patricia Boyer, MSM, RN, NHA,** an operations consultant in Brookfield, WI.

A restorative program that automatically integrates task segmentation, as appropriate, "can be extremely successful," Boyer
adds.

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