Long-Term Care Survey Alert

Resident Care Documentation: SIDESTEP FEDERAL CRACKDOWN ON FALSE DOCUMENTATION

Federal regulators are now targeting falsified resident care records, so make sure your staff chart accurately and truthfully when something bad happens to a resident. "Federal officials believe in their heart of hearts that nursing home records are suspect," cautions

Washington attorney **Marie Infante** in a presentation at the recent **American Health Care Association** annual convention in New Orleans.

"And the government has no hesitation in aiming its guns at corporate entities or individuals," Infante observes. As an example of how far prosecutors are willing to go, Infante points to the case of **Lisa Taibi**, an LPN sent to federal prison for 10 months last year for falsifying a resident's care record.

Taibi reportedly changed medication records to make it look as though she had lowered a resident's Coumadin dosage as ordered by the physician, when she had not. The resident subsequently died of internal bleeding in the hospital

"Nursing facilities that have strict and enforced policies forbidding falsification of records and continual training programs for personnel in this regard can avoid criminal prosecution," says **Harvey**

Tettlebaum, an attorney with **Husch & Eppenberger** in Jefferson City, MO. Even so, nursing facilities can be cited or even decertified for false documentation, he says. And use of doctored documentation as a basis for billing payers opens a potential Pandora's box of false claims actions at the federal and state levels.

As a first step to protect your facility from false documentation, develop written ethical policies and expectations for health professionals working in the facility, advises **Beth Klitch**, principal of **Survey Solutions** in Columbus, OH. Communicate these policies to staff as part of orientation and inservicing.

And make sure caregivers understand the legal consequences of falsifying a resident's medical record. "By saving employees from themselves, administrators can save the facility from adverse consequences," Tettlebaum emphasizes.

"Nurses should understand that what happened to Taibi could happen to them," warns **Annaliese Impink**, an attorney with the **Law Offices of Bianculli & Impink** in Arlington, VA.

Even if caregivers caught falsifying care records don't get a "go directly to jail" card, they can lose their license or certification or end up on a state list of disqualified employees. In addition, make sure the facility's policies and procedures spell out how staff should document adverse events.

"It's best to write down the facts as soon after the incident as possible," Klitch says. In other words, you can't wait to do an entry 30 days after the fact when you know the resident died in the hospital due to an accident. "That won't pass the 'smell test,'" Klitch says, even if you eventually did try to chart what really happened.

Klitch also advises impounding charts immediately after a serious adverse event so that charting occurs under supervision right after the resident has been sent to the emergency room or stabilized.

Don't Go Overboard

Sometimes staff engage in another form of false documentation by exaggerating a situation or jumping to a conclusion in writing, which can also get a regulatory snowball headed to your door.

For example, one nurse documented that she found a resident "face down in a pool of blood" after a fall, reports **Jacqueline Vance**, director of clinical affairs for the **American Medical Directors Association.** Vance spoke at the recent **American Association of Homes & Services for the Aging** annual conference in Baltimore. In reconstructing the accident, Vance found that the resident, who had Parkinson's disease, froze as she tried to sit down and fell face first. The "pool of blood" came from a bloody nose.

"Luckily, surveyors agreed to review the plan of care and also the emergency room assessment, which did not show any blood loss or a broken nose," Vance relates. Surveyors could see the care plan sought to minimize the resident's risk of falls and significant injury.

In retrospect, the nurse could have written "resident found face down on floor. Nose bleeding copiously," says **Joseph Bianculli**, an attorney with the **Law Offices of Bianculli & Impink** in Arlington, VA. To set the record straight in cases where the original note may be a bit melodramatic, staff can document additional facts as an investigation into an adverse event evolves.