Codify
BY AAPC

Long-Term Care Survey Alert

Risk Management: These Documentation Strategies Can Keep Surveyors and Litigators Off Your Case

Beware injecting personal bias -- or leaving room for the reader to do this.

Solid medical record documentation can provide one of your best sources of protection against everything from survey citations to payment audits and civil litigation.

Key: The documentation should tell a "factual, unemotional story," advises attorney **Mary Malone,** with Hancock, Daniel, Johnson & Nagle PC**.** For example, "you have to be careful of your word choice."

Malone recounts one situation where a cognitively impaired resident "whom no one had complained about would go around hugging and patting everyone. One of the nurses characterized this behavior in the nursing notes as 'fondling' other residents. While the nurse didn't mean this to be negative, that word for most people -- and certainly for surveyors -- has a very negative connotation," Malone says.

Don't Open the Door to Conjecture

"The documentation should also give a full story so there aren't holes for surveyors and plaintiff attorneys to fill in, thereby creating a very different story," Malone warns.

Example: Suppose the nursing notes indicate that a patient seemed agitated and was crying, but there's no documentation showing how staff responded, Malone says. "It might have been that the resident got a letter from a granddaughter that made her emotional, and the caregiver talked to her for a few minutes and the resident calmed down." If you don't document that piece, however, someone could use the incomplete note to help make a case that the facility neglected a resident in distress, Malone warns.

Give Staff Reasons to Document Appropriately

Teaching staff not only what to document but also the rationale for doing so can pay off.

When staff members know why they should do something, they have a reason to comply other than just because management told them to, observes attorney **Paula Sanders** with Post & Schell in Harrisburg, Pa. "They know their actions affect payment and compliance -- or that they themselves could get into trouble."

For example, caregivers should know to always document high-risk care, such as turning and repositioning, Sanders says. But they should not document care they plan to do before providing it, she stresses.

Backdating Can Be a Date With Future Disaster

Backdating medical records can lead to major problems for the facility, as well as professional licensure actions or even prosecution for those who falsify the record.

Cautionary tale: Sanders knows of a Statement of Deficiencies that said the RN assessment coordinator and director of nursing backdated electronic care plans. "According to the public record about the survey, the surveyors had an issue about a certain type of wound treatment," she reports. So, they asked to see the care plan for a certain date and had more questions. The next day, the nursing staff handed surveyors what they claimed to be an earlier care plan. "But the surveyors could tell by the electronic time stamp that the care plan had been backdated," Sanders reports.

"Backdating electronic records is very dangerous because the systems are set up to create a record every time a file is

accessed," Sanders says. "That's why it is critically important to safeguard passwords and personal log-in information." You don't want anyone logging into an EMR "pretending to be you."