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MDS Alert

Risk Management: All May Not Be Lost If Medical Record Documentation Doesn't Back You Up

There are other ways you can prove the facility didn't violate the regs.

Taking a closer look when surveyors find documentation shortfalls can keep you from landing in a pile of F tags.

Attorney **Paula Sanders** reports handling a case where a facility got cited for failing to care plan a specific resident's fall risks. "The surveyors had looked at the resident's care plan and said they didn't see any changes between one fall and the next," says Sanders, with Post & Schell in Harrisburg, Pa.

The facility took the case to informal dispute resolution where staff showed that they had implemented fall-risk prevention interventions in the activities room, which is where the resident's fall had occurred, Sanders reports. In addition to the fall reduction effort in activities, the facility also had more staff in place, she adds.

Lesson learned: You can point out those kinds of efforts, but the facility should also include them in the residents' care plans, if possible, Sanders counsels.

Attorney **Mary Malone** has also used strategies at IDR "to fill in the gaps when the documentation doesn't tell the whole story." She finds that "hearing officers at IDRs tend to be more interested in looking at the entire picture based on any evidence you can provide." By contrast, surveyors are focused on the documentation they have in front of them, adds Malone, with Hancock, Daniel, Johnson & Nagle, PC in Glen Allen, Va.

"You have to do things outside the box when you can't prove that something happened through documentation," Malone stresses.

Example: "One facility got cited because the surveyors said the facility was serving food that was past the expiration date," says Malone. The facility didn't have documentation on that, but it determined that the food was served past the "best used by date" rather than the true expiration date. "We got publicly available information that explained the FDA's definition of 'expiration' versus 'best used by' date," Malone relays.

Tap Witnesses, Use Addendums

If the facility did provide services that staff failed to document, you can "absolutely go back and get statements from patients, families, and staff to indicate that the care was provided," Sanders relays. An example includes turning and repositioning to prevent or treat pressure ulcers. "You can also do a late entry to document services" with the late entry clearly indicated as such, she adds.

Addendums to the medical record need "to be dated, timed, and signed at the time you actually provide the clarification," stresses Malone. "There's nothing wrong with doing that," she adds, noting that she'd rather see a facility correct or clarify a record than not. "But facilities shouldn't routinely rely on that strategy," she warns. "I have found people in every context (survey, medical malpractice, payment audits) are very skeptical about after-created documentation."