Nursing Home Investigation Tips Cheat Sheet

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1. FACE SHEET/LEGAL DOCUMENTS:

Demographics needed for Twist report. Usually located at the very front or very back of the medical record. Tells full name of resident (with correct spelling), date of birth, date of admission to the facility, social security number, diagnoses, previous address, family members and phone numbers (for possible collateral interviews), responsible party and/or guardian, attending physician, etc. Legal documents may include POA, Guardian, and code status of the resident.

2. HISTORY & PHYSICAL/DISCHARGE SUMMARY

H&P should be done annually by physician, P.A., or nurse practitioner. Gives a picture of the resident's physical and mental health at the time of exam. Useful when trying to determine if a decline in status occurred. Discharge summaries are useful for past history and overview of resident status.

3. PHYSICIAN'S ORDERS

Care and services must be provided in accordance with physician's orders (definition of neglect). Orders are always important in any investigation of neglect. Specific medication orders must be known before an error can be validated. If a pressure sore is not responding to treatment, look for changes in orders to promote healing. If the problem is weight loss, look for orders to address addition of supplements, vitamins, dietary changes, etc. When a resident experiences any significant change in status, the orders should also reflect changes to address the problem.

4. PHYSICIAN'S PROGRESS NOTES

Provides important insight in to how often the physician sees the resident, how involved he/she is in the care, and notes progress, stabilization, or declines.

5. NURSING NOTES

Documents the day to day occurrences. Should be descriptive, factual, timed, dated, and each entry signed by the LPN or RN scribe. Nursing documentation can be invaluable in neglect investigations. Lack of proper documentation combined with a negative outcome for the resident can support substantiation of neglect.

5. NURSING NOTES (cont)

Whereas, good descriptive documentation can unsubstantiate neglect, even in the presence of decline at times. The cardinal rule taught in nursing school and observed by the Courts, "If it wasn't charted, it didn't happen.".

6. MDS (Minimum Data Set) 3.0 ASSESSMENT

The first part of a three part state mandated assessment tool to be utilized by all skilled nursing homes in Kentucky. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. Assessments are mandated at specific times, i.e., upon admission, quarterly, annually, significant change in status, and at each hospitalization and return to the facility. The assessment is used to ensure all facilities adequately and accurately review all body systems and identify problems that need to be addressed. Only MDS assessments pertinent to the time frame of the allegation should be reviewed and provide good indicators as to whether or not the facility was aware of developing medical problems..

7. CAAs and CATs

The second part of the state mandated assessment tool. The Care Area Assessment (CAAs) are a structured, problem oriented framework for organizing the MDS information. The CAAs help identify and analyze social, medical, and psychological problems, forming the basis for planning care. For example, the Cognitive CAA will tell all about the mental capacity of the resident, from memory to decision making abilities. The Nutritional CAA would describe feeding problems, causal factors, referrals, studies, etc.. The CATs (care area triggers) gives an overall picture of the resident's functioning level.

8. NURSING/NURSE AIDE CARE PLAN

The third part of the state mandated assessment tool. The MDS assessment identifies the resident's problems. The CAAs analyze the problems and consider the resident's strengths/weaknesses. All that information is used to develop a comprehensive care plan with goals toward improving function, preventing avoidable declines in functioning, managing risk factors, and promoting care in accordance with physician's orders and current professional standards of practice. For every allegation of neglect, the care plan should be reviewed to determine whether or not the problem was being addressed. The Nurse Aide Care Plan may also be called resident assessment tool or nurse aide flow sheet. Nurse aides usually document on these sheets the direct care provided daily..

9. DIETARY RECORDS

Assessments are done by a registered dietitian, and day by day monitoring documentation is usually done by the dietary manager. The dietitian assesses the resident's admission body weight, ideal body weight range for height, and desired body weight. At least monthly weights are recorded, more often as needed. The dietitian documents the resident's estimated caloric needs and daily fluid needs. Dietary notes are especially important in allegations of weight loss and/or dehydration. First, determine if the weight loss was desired and planned for, i.e. through physician's orders for an exercise program and weight reduction diet. If not, then determine if the weight loss was identified and addressed by the dietitian. Were dietary supplements, increased calories, increased protein, multivitamins, appetite stimulants, etc. recommended? Did the dietitian's recommendations get to the physician for orders? Were labs (albumin and protein levels) monitored to ensure adequate protein stores? If not, question why..

10. INTAKE/OUTPUT RECORDS

Especially important in allegations of dehydration. Records amount of fluid intake (orally, parenterally (I.V.), or by gastric tube) and the amount of output, either by voiding or Foley catheter. Compare the amount of fluid intake to the dietitian's recommended daily fluid requirements to see if needs are being met. If not, that's a problem. Determine how the facility addressed this.

11. MEAL CONSUMPTION RECORDS

Records the intake at each meal and snacks provided. Usually recorded in percentages. Review for allegations of weight loss and/or dehydration. Review the dietitian's recommended caloric and fluid requirements, then determine if the resident's needs are being met. If not, question whether or not the facility has done a calorie count to determine exactly what the resident is consuming.

12. TREATMENT RECORDS

ocument the specific problem, location, description of the site, response to treatment, and all changes in treatment orders. Some facilities use photographic documentation also. These records are especially important in allegations of pressure sores, wound infections, failure to provide treatment, etc. Treatment records may also include bed, body, and chair alarms in use; incontinence care.

13. Medication Administration Records (MARs)

Documentation of all medications administered. Allergies should be noted on the MAR sheet, usually in red ink to draw attention. MARs should document name of the medication, type of administration (orally, rectally, injection, etc.), month, date, time, initial and signature of person giving. **PRN (as needed) medications** should also include a record of follow up response to the medication. MASTER SIGNATURE LIST: this should include all of the nursing and nurse aides signatures in case there is a question about who made an entry in the medical record; they can cross-reference on this signature list..

14. FLOW SHEETS/SKIN ASSESSMENTS

Includes things such as turning/positioning, ambulation, range of motion exercises, bathing, bowel/bladder output, etc.

15. LAB VALUES/X-RAYS

These reports are critical documents useful as evidence to support findings.

16. INTERDISCIPLINARY NOTES

Notes by professionals involved in the care of the resident, i.e.; Physical Therapist (P.T.), Occupational Therapist (O.T.), Speech Therapist (SPT), Pharmacy Reviews (RX), Psychiatric, Wound Care, and Social Services (SSW).

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17. RISK ASSESSMENT TOOLS

Periodic assessments to include Braden Scale (skin assessment), pain, elopement, falls, restraints, mechanical lifts, and side rails. These are done at least quarterly and following an event.

Additional Documents

Additional documents that may need to be requested, but are not found within the medical chart are as follows:

1. INCIDENT REPORTS/UNUSUAL OCCURRENCE: First and foremost, this is a facility document which they are not legally required to provide copies. However, under KRS 209 they do have to allow you access to these documents for review upon request. These documents may reveal information that will not be recorded in the medical chart, such as falls, elopement, etc.

2. POLICY/PROCEDURES: Useful during investigation to evaluate if facility staff are delivering care and services in accordance with developed guidelines.