

Illinois Department on Aging
**Illinois Long-Term Care Ombudsman Program
Supplemental Training Curriculum**

**Supplemental Module # 14
Understanding Residents' Records
During Complaint Investigation**

Pre-publication Edition I

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**Credit to David Sutterfield and Margaret Niederer for their
contributions in the development of this module**

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PROCESS FOR USING THIS MODULE

The supplemental modules for ombudsmen have been created to accommodate different learning styles and are based on research about how most people learn. The premise on which this module is based is the idea that new information is learned best when there is an opportunity for discussion and to ask questions.

The information in this module was originally prepared by David Sutterfield, Attorney at Law, for use in court cases. Ombudsmen most often will not need to review all of the included resident records during complaint resolution. You must select which records are pertinent to each specific case.

This module serves two purposes:

- 1) A training document; and
- 2) A prompt—When an ombudsman has a complaint, this module can be taken to the facility for the ombudsman to use as a checklist when reviewing resident records.

After the discussion, you will be asked to complete the following accountability exercises:

- 1) Review a prior case from your area and determine what resident records (identify no more than 5 records) needed to be reviewed and why.
- 2) Write at least five questions, but as many questions as you have, about the information in this module.

PURPOSE OF THIS MODULE

The purpose of this module is to:

- Inform ombudsmen of the components of a resident's record.
- Explain how the resident records components can be used when investigating a complaint.
- Provide guidelines for fully documenting resident and systemic concerns/complaints.
- Provide basic information on how to make a complaint to the Illinois Department of Public Health.

SUPPLEMENTAL MODULE # 14 UNDERSTANDING RESIDENTS' RECORDS DURING COMPLAINT INVESTIGATION

I. INTRODUCTION

Nursing home residents are among the most vulnerable members of our society. They are dependent upon the caregivers at the nursing home for their day-to-day well-being because of their physical and mental frailties. The very fact that nursing home residents have physical and/or mental impairments inhibits their ability to advocate for themselves. It is important for ombudsmen and family members to support residents and fill an advocacy role. This responsibility cannot be met without an understanding of what is or is not acceptable under the law and how to investigate and obtain proof of deviations from nursing home care standards.

Governing Law

Nursing home care is governed by federal and State law. The federal statute is known as the Nursing Home Reform Law within OBRA (Omnibus Budget Reconciliation Act). The federal act has accompanying regulations commonly known as the OBRA Regulations. These regulations are distributed in the State Operations Manual. The applicable Illinois statute is known as the Nursing Home Care Act. Illinois also has regulations that detail the responsibilities of nursing home license holders in accord with the Nursing Home Care Act. These can be found in the 77 Illinois Administrative Code 300.

Basic Premises of Nursing Home Standards

Every nursing home owner has the responsibility to administer his facility "in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Anything less is unacceptable.

The care and services must be provided in accordance with the comprehensive assessment and plan of care for the resident. The facility must have sufficient nursing and other staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by its individualized resident assessments and the care plan developed for each resident.

The Ombudsman's Advocacy

Many cases of resident concerns are easily resolved by informing and empowering residents, or by addressing the issues with facility staff on behalf of an individual or

group of residents. However, some cases can involve extensive investigation, including the review of written records and documentation, in order to obtain all the facts necessary for investigation. For example, cases involving 1) residents who have communication problems, 2) information from staff contrary to information provided by the resident, 3) complex medical issues, and 4) abuse and/or neglect will likely require the ombudsman to access a resident's records.

II. DOCUMENTATION IN A RESIDENT'S RECORD

Nursing home resident charts have documentation that is unique. These documents allow a reviewer to determine how the resident was initially assessed; how her care was planned, based on the assessment; and what care was actually provided to the resident.

Two important documents are the **Minimum Data Set (MDS)** and the **Care Plan**. The MDS is a core set of screening, clinical and functional elements, which forms the foundation of the comprehensive assessment of a resident. The resident assessment process helps staff to look at the resident holistically, as individuals for whom quality of life and quality of care are mutually significant and necessary.

The **MDS** is to be completed within fourteen days of the resident's admission to the facility. The resident's Care Plan is to be completed by the twenty-first day. The day of entrance counts as day one. The Care Plan is to meet all of the resident's physical, mental, and psychosocial needs as identified in the MDS. If the Care Plan proves not to meet a resident's needs, or there is a significant change in the resident's condition, a new MDS is to be completed and the Care Plan modified accordingly. The ombudsman needs to be aware that the **MDS** form may not reflect the resident's current condition, if a reassessment was not completed when the resident's condition changed.

Other than the **MDS**, other parts of a resident's record may include the following, but keep in mind that the facility has the right to set up its own documentation system, so you might not see all these particular forms:

Record	Completed By
1. Face Sheet (Admission sheet)	
2. Nurses' Notes—progress notes and weekly/monthly summaries of care provided/status of resident	
3. 24 Hour Reports (usually kept no longer than one month)	Nurse
4. ADL (Activities of Daily Living)	Nurse
5. Incident reports—an incident is when there is some type of accident, injury or	

possible injury to a resident	
6. Preadmission Screening and Annual Resident Review	Level I –CCU Case Manager Level II –PAS agent
6. Skin Records <ul style="list-style-type: none"> • Skin treatment records • Pressure sore reports • Pressure sore risk assessment • Non-pressure sore skin report 	
7. Fall Assessments	Nurse
8. Dietary Assessments	Dietary personnel
9. Physical Therapy—assessment, progress notes, discharge notes	Physical Therapist
10. Occupational Therapy—assessment, progress notes, discharge notes	Occupational Therapist
11. Speech Therapy—assessment, progress notes, discharge notes	Speech Therapist
12. Activity Assessments	Certified Activity Director
13. Social Services Assessments and Progress Reports	Social Services
14. Flow Sheets <ul style="list-style-type: none"> • Activities of Daily Living (ADLs) • Turning and Positioning Records • Vital Signs and Weights • Intake/Output Records 	Nurse CNA CNA CNA
15. Transfer Records	Nurse
16. Ambulance records	
17. Hospital Records	Hospital Nurse
18. Physician's Orders <ul style="list-style-type: none"> • Those written at the facility • Telephone orders 	
19. Physician's Progress Notes	Physician
20. Medication Administration Records (MAR)	Nurse

NOTE: Certified Nursing Assistants, responsible for daily assessments of skin, etc., cannot chart any of the assessment records.

The facility has the right to set up its own documentation system, with the exception of the MDS form. Knowing the purpose of a record can assist in finding a particular resident's record under a different name than those listed above.

III. INITIAL RECORD REVIEW

Please refer to the Level II ombudsman training *Access Module* to determine the process for and under what circumstances to review a resident's record.

When the ombudsman begins to investigate a complaint that requires reviewing a resident's record, the following sequence will provide an efficiency of time.

Start with the **Minimum Data Set (MDS)**.

- 1. Does it actually describe the resident?
If the MDS does not accurately describe the resident, take note of the errors.
- 2. Was it done in a timely manner?
- 3. Was it accurate at the time?
- 4. If the assessment is not accurate, it is unlikely that the needs of the resident can be accurately planned for and met.

Review the **Care Plan**—which should be developed by facility staff with resident and family (with resident's permission).

Note the following as applicable to the complaint.

- 1. Is it consistent with the resident's needs?
- 2. Is it consistent with the MDS?
- 3. Is it being followed, or is it merely form over substance?
- 4. Is the Care Plan accessible/reviewed by staff?
- 5. Ask the appropriate staff if they know what the Care Plan provides for a particular problem.
- 6. The Care Plan may be consistent with the resident's needs, but is not working. Why not? Is it not being followed consistently or not at all?
- 7. Has the Care Plan been distributed to all direct care staff, which includes Certified Nursing Assistants (CNAs)?
- 8. Is there insufficient staff to carry out the Care Plan?
- 9. Is the staff qualified and trained properly?
- 10. Is the family interfering with the care?
- 11. Is the resident resisting care? (Is the resident capable of resisting care?)

Review the **Nurses' Notes**

- 1. What do the Nurses' Notes state about the condition/incident?
- 2. Do the notes even mention the condition/incident?
- 3. If so, do the notes accurately describe the condition/incident?
- 4. Are the notes consistent with the other records? (see the Incident Report and 24 Hour Reports below.)
- 5. Are there big gaps of time or care in the Nurses' Notes?
- 6. Does a nurse who never cared for the resident suddenly appear in the chart?
The condition/incident could be the result of a nurse unfamiliar with the resident's conditions/needs.

The facility may have had an experienced and loyal nurse take over the charting in an effort to explain away the condition/incident.

- 7. Do the Nurses' Notes appear altered?
Signs of alteration include erasures, white outs, out of order time entries, insertions, and large space gaps between notes.

Review the **Incident Report** (Ombudsmen don't have guaranteed access to these reports. Request to IDPH issued May 2003 on this issue—check with supervisor.)

- 1. What does the Incident Report state about the condition/incident?
- 2. Does it accurately describe the resident?
i.e.—If the resident supposedly became injured while walking, and the resident is comatose and bed-bound, the injury would be improbable and an indication of an attempt to cover up an error or intentional act of the facility staff.
- 3. Was the Incident Report prepared by the same nurse who appears in the Nurses' Notes?
- 4. Was it prepared contemporaneously with the incident or a significant time later?

Review the **24-Hour Reports** (Ombudsmen don't have guaranteed access to these reports.) –24-Hour reports are a means for one shift to communicate with another. The Director of Nursing may also use the 24-Hour reports to monitor the condition changes of residents, schedule doctor's visits, etc. 24-Hour reports are purged from a resident's chart at least monthly, sometimes weekly. A facility may not have these, or may use tape-recorded messages instead of written reports.

Review the **Physician's Orders**—need to be cross-referenced with the Nurses' Notes, treatment sheets, and the medication administration record.

- 1. Is the physician ordering treatment for a condition that the nurses never described in their notes?
- 2. Do the Nurses' Notes state that the doctor was informed of a significant change in the resident's condition?
- 3. Is there a corresponding entry in the physician's orders or telephone orders?
- 4. Is the change in treatment reflected in the treatment sheets and/or the medication administration record?

NOTE: Some facilities keep the **Treatment Records, Medication Administration Records, Bowel and Bladder Records** separately. If these records are not complete in the nursing records, ask for the treatment, medication, bowel/bladder, and any other records.

IV. REVIEW RECORDS THAT RELATE TO A PARTICULAR COMPLAINT

The records noted above are general and relate to any and all complaints about the care of a resident. Some records may be particularly relevant to the complaint while others may not. Notwithstanding the fact that some records may be more specific to the problem or incident one is investigating, all records should be reviewed for integrity of the entries.

It is important to validate, if possible, the information found/not found in the resident's records by making your own observations and by talking to the resident's family, physician and **appropriate** nursing home staff.

NOTE: Depending on the facility, the CNAs may or may not document in residents' records.

Concern/Condition	Relevant Records
Bedsore	<ul style="list-style-type: none"> <input type="checkbox"/> 1. Skin treatment records <input type="checkbox"/> 2. Pressure sore reports and risk assessments <input type="checkbox"/> 3. Turning schedules—(Where and when do CNAs complete these? Do they do them all at the end of a shift or contemporaneously with providing service to the resident?) <input type="checkbox"/> 4. ADLs <input type="checkbox"/> 5. Vital signs and weight <input type="checkbox"/> 6. Intake/output records <input type="checkbox"/> 7. Dietary assessment <input type="checkbox"/> 8. Social services records <input type="checkbox"/> 9. Laboratory reports of tests for MRSA or other infectious diseases—Is the report back? Does the chart show the results were reported to the physician (promptly)? <input type="checkbox"/> 10. Physician Orders—Was the resident assessed at high risk? Are there preventative or treatment orders? Did the facility accurately inform the doctor of the resident's condition?
Dehydration	<ul style="list-style-type: none"> <input type="checkbox"/> 1. Intake/output records <input type="checkbox"/> 2. Vital signs and weights <input type="checkbox"/> 3. Medication Records <input type="checkbox"/> 4. Speech Therapy—Does the resident have difficulty swallowing? <input type="checkbox"/> 5. Social Service records and other records of cognitive function that reflect whether the resident can be expected to have proper fluid intake without staff assistance/intervention.

	<input type="checkbox"/> 6. Physician's orders
Malnutrition	<input type="checkbox"/> 1. Intake/output records <input type="checkbox"/> 2. Vital signs and weights <input type="checkbox"/> 3. Nurses' Notes—details of observations of swollen tongue, dried/cracked lips, skin swelling due to high fluid content, etc. <input type="checkbox"/> 4. Percentage of food eaten on Nurses' Notes versus food intake records <input type="checkbox"/> 5. Speech therapy—does the resident have difficulty swallowing? <input type="checkbox"/> 6. Social Service records <ul style="list-style-type: none"> a. Cognitive function—whether the resident can be expected to have proper nutritional intake without staff assistance/intervention. b. Are food preferences of the resident noted and followed? <input type="checkbox"/> 7. Physician's Orders—Are dietary supplements ordered? Cross check with intake records to see if they are given. If not documented here, review the medication record for documentation. <input type="checkbox"/> 8. Dietary assessment <input type="checkbox"/> 9. Risk assessment records
Falls and Fractures	See "Misuse of Chemical and Physical Restraints" section below.
Misuse of Chemical and Physical Restraints	<input type="checkbox"/> 1. Risk assessment <input type="checkbox"/> 2. Restraint records <input type="checkbox"/> 3. Cross reference Care Plan and Nurses' Notes to see if a restraint reduction program was implemented and followed. <input type="checkbox"/> 4. Medication Administration Records—look for psychotropic medications <input type="checkbox"/> 5. Physicians Orders—Did the doctor order a restraint? Why?
Contractures	<input type="checkbox"/> 1. Physical Therapy Assessment <input type="checkbox"/> 2. Occupational Therapy Assessment <input type="checkbox"/> 3. CNA Restorative Motion Records
Wandering/Behavior Management	<input type="checkbox"/> 1. Cognitive Assessment Records <input type="checkbox"/> 2. Activity Assessment and records <input type="checkbox"/> 3. Medication Records <input type="checkbox"/> 4. Behavioral tracking records <input type="checkbox"/> 5. Physicians Orders and progress reports <input type="checkbox"/> 6. Hospitalization records <input type="checkbox"/> 7. Consultative physician reports and

	recommendations
Medication Errors	<input type="checkbox"/> 1. Medication administration records <input type="checkbox"/> 2. Physician's orders <input type="checkbox"/> 3. Cognitive assessments

Care Plan Conferences

The resolution of many complaints requires the ombudsman to attend a care plan conference with the resident and/or his or her family. When attending a care plan conference, consider the following:

- Is a licensed nurse in charge of running the meeting?
Federal law requires that the care plan coordinator be a licensed nurse and that the plan be signed by a Registered Nurse.
- Is more than one nursing home staff member in attendance?
A team of staff from multiple disciplines should write care plans and coordinate care plan conferences.
- Is the resident present?
All residents and/or designated representatives should be informed of the date, place and time of their care plan conferences and informed of their right to attend.
- Is the resident's family present?
If the resident wishes, family members must be informed of and allowed to attend the care plan conferences.
- Are the resident and family members actively participating in the care plan conference, indicating the resident's individual needs and preferences for care?
It is a resident's right to participate in the planning of his/her own care. Facility staff should not simply inform the resident and family of the contents of the care plan, but allow the resident and family to contribute to all parts of the care plan.
- Are individuals signing the attendance sheet for the care plan conference really in attendance?

V. OTHER SOURCES OF VALUABLE INFORMATION

Know the nursing home staff by name and position.

1. Are they new or experienced at the home?
2. Are they "pleasant"/"professional"?
3. Are they an apologist for the facility or have they articulated complaints about the facility/working conditions/staffing/staff qualifications/staff training?
4. Are the CNAs licensed or are they at the facility on a training basis (this is common in understaffed facilities with high turnover)?
5. To answer questions #1-4, take the time to talk with staff, observe staff, and inquire about residents' and families' experiences with different staff.
6. Staff who leave the facility are a potential source of information. Call or meet him/her to describe relevant problems at the facility. They are trained and,

because they work there and have spent more time at the facility and other facilities, they probably have insights that ombudsmen do not have.

Write it down.

1. What was observed?
2. Where was it observed?
3. When was it observed?—date, time
4. Who observed it?
 - Obtain the names of everyone present, even staff members—a staff member may claim to have been there when he wasn't.
 - Obtain the addresses and phone numbers of those present.
5. What was said?
6. Where was it said?
7. Who said it?

Photos are strongly encouraged. The best of all worlds is a video camera that imprints the date on the video. The next best choice is a camera that takes still pictures and imprints the date on the picture.

Audio taping without the consent of the other party could be a violation of Illinois criminal law. The statute has been redrafted twice by the Illinois legislature in response to Illinois Supreme Court decisions striking it down as unconstitutionally vague.

VI. ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The Department of Public Health's Division of Long-Term Care Field Operations is responsible for conducting certification surveys and individual complaint investigation surveys to ensure facilities receiving Medicaid (state) or Medicare (federal) money for resident payment abide by applicable federal regulations.

Complaint Methods to the Illinois Department of Public Health

The Department operates a nursing home hotline for telephone complaints. The telephone number is **1-800-252-4343** or **1-800 526-0844 (TTY)**.

The complainant should send a written complaint. In an emergency, a telephone complaint should be made, but should be followed up with a written complaint. The address to write to is:

Illinois Department of Public Health
Central Complaint Registry
525 West Jefferson Street
Springfield, Illinois 62761
Fax: 1-800-881-4175

Your regional program may require a written complaint to be sent by certified mail. Certified mail forms are available from any U.S. post office. Pick up a certified mail form prior to sealing and sending the complaint to the Department of Public Health. Your letter should reflect the number of the certified mail receipt. Keep a copy of the complaint and all supporting documents, including the certified mail receipt number. This allows you to match your letter up with the certified mail receipt in the event the letter is lost.

Contents of Complaint

Carefully consider whether lack of staffing and/or untrained staff, is a component of the problem. If you determine staffing to be part of the problem, document the number of staff you observe on a shift. Keep your eyes open regarding your own observations, noting the date and time, if occasional or perpetual, or if there is a severe understaffing exceeding the typical shortage. Keep your ears open for staff complaints, noting the date, time, and staff member complaining about staff shortages/training. Do not hold back—everything should be included (the proverbial kitchen sink). Be specific. Provide all the details, names of witnesses (with their consent), dates, times, places, phone numbers, etc. Provide copies of all supporting documentation and photos.

VII. SUMMARY

This module only describes the basics of nursing home resident records. Each facility may differ in record keeping and documentation policy. Each case is unique and may require access only to specific parts of a resident's record.

Best practice dictates that an ombudsman would understand the policies and procedures of the nursing facility to which he is assigned before the necessity of record review arises.

Most importantly, an ombudsman should contact his supervisor for guidance on the first cases he handles that involve resident records review until he feels comfortable in reviewing records independently.