N-15 Medicaid Waiver documentation

Purpose: To clarify points to consider when recording data for a Medicaid Waiver (MW) resident.

Medicaid:

Medicaid is a federal and state funded health insurance program for low income individuals. Medicaid waiver helps pay for care of disabled elders in the community (Pioneer Home) rather than in a skilled nursing facility. Medicaid is paying the bill and Medicaid writes the plan of care (POC).

The Senior & Disabilities Services (SDS) runs the MW program. An SDS nurse assesses the resident to see if the resident meets the level of care needed for the MW. If level of care is met, a care coordinator assesses the resident and writes a POC. The Home reviews the POC, agrees to the services, and documents the services. Read the POC carefully, review it with the Home administrator. Do not sign the POC if the services are not routinely provided. Signing the POC indicates that the Home will provide the stated services. Each year the SDS nurse re-assesses the resident and a new POC is signed.

Keep the *current* POC in the resident's chart, to show that you are following the current plan. The POC start date and the POC end date are found in the header at the top of each page in the POC. If the Home doesn't have a revised plan by the end date, contact the care coordinator and enter a short note into AccuCare about the contact; this is good communication.

There are 14 services listed on the POC.

1. Nutrition, eating, feeding
2. Bathing, hygiene, grooming
3. Toileting, incontinence care
4. Skin care
5. Dressing
6. Mental status, orientation, memory, behaviors
7. Medication management, supervision, assistance
8. Laundry, housekeeping chores
9. Mobility, ambulation, safety
10. Socialization, activities
11. Other needs – weight, vital signs, treatments, skin/wound care
12. Other needs – monitor seizure activity, chest pain, edema
13. Transportation to medical appointments
14. Communication with other caregivers

AccuCare:

AccuCare is the computer system that the Pioneer Homes use to document and store resident data. Data includes admission, census, face sheet data, medications, activities of daily living, quarterly assessments, and progress notes. AccuCare organizes, clarifies, and creates permanent records that are quickly accessible, legible, and don't require storage space. The records can be seen without traveling to the Homes and can be viewed 24/7 without using phone, fax, scan, or other staff members' time.

Resident information is entered into the AccuCare system, and flow sheets are printed. CNAs record activities of daily living (ADL) on these flow sheets with initials each shift.

A record contains:

- Resident name, individualized for that resident
- Date/shift
- Service provided, including extent of service
- Sign/initial by the staff providing the service

Printed records of services for a MW resident are organized, easy to interpret, and quickly accessible. These records are kept for at least 7 years.

Flow sheets:

Flow sheets give the CNA a complete picture of what is being done for the resident, rather than breaking up the services to different documents.

Write with black ink on white paper. Black is the most commonly used color on legal documents because it reproduces well. Black print on white paper photocopies more clearly than any other color combination, and contrasts best in digital scans. Black ink fades less and lasts longer. Don't use marker ink because it bleeds through the paper.

Don't scribble over an error so that it is unreadable. Draw a line through the incorrect entry, initial it, and write the correction above or on the back of the page. The flow sheet is a medical record and random marks and lines should be avoided.

When making an entry, always initial it. Be alert to which box/row is assigned for charting. Haphazard notations are an alert to the reviewer/auditor that the person is not reading what is being signed.

The flow sheet has a ¼ inch box that corresponds to a particular day, shift, and service. Initials are contained within the ¼ inch box. Initials that extend into surrounding boxes, distort initials in adjoining boxes, and can look sloppy and scribbled.

If a service is not documented/initialed, it didn't occur. Gaps are empty boxes without initials. Don't initial a box if the task was not done, but if the service was provided, *initial it*. For example, the CNA does a lot of work when bathing a resident, and the bath must be recorded to receive credit for time spent. The auditor interprets a bathing gap (no initials) as a bath not given. Vital signs that were not recorded were not taken.

Gaps and blank sections are a warning signal to auditors. Medicaid QA tolerates an occasional random gap, but not multiple gaps or gap patterns. A gap pattern is when the same day or days each week are not initialed.

If a service is not performed on a certain shift, omit that shift or enter XXX's by that shift when the ADL is printed. Don't ask the CNA/LN to initial a box if the task is not performed on that shift. If a behavior is not logged, or safety devices are not used on night shift, remove the shift from the flow sheet/MAR. For example, insomnia on the behavior log is not monitored on day and evening shifts.

Minimize documentation time and clutter that is not needed. Avoid unnecessary words and options; simple, concise wording is most effective. Flow sheet documentation should closely follow the MW POC. If a service needs only initials, provide only one line to document. If a service needs 3 lines for initials and codes, then provide only 3 lines to record. Avoid unneeded check marks and confusion.

A flow sheet template states the same services for each resident, with little difference in care between residents. Customizing the template provides essential information to the caregiver. Individualized flow sheets reflect the orders on the POC, such as Foley catheter care, Ensure TID, alarm check, hearing aid check, shampoo weekly, etc. The care coordinator often includes details about the resident's care. Details give direction but also require documentation. The flow sheet used by the CNAs each day can provide information, not just a series of boxes to initial.

An FYI is an information reminder, not a service provided. Entering FYI (for your info) under HOUR clarifies that initials are not needed. Use of XXX's on the flow sheet for indicating that initials are not needed is a good practice. The DNR code status or instruction to crush medications gives information. When care givers initial such information, it indicates that they did not read the words.

Utilize as per care plan is meaningless unless the CNA knows the care plans and refers to the plans continually. Gathering the pieces of info together in one location provides a complete information source for the CNA.

Dietary sends the trays of food for the residents. Type of diet is on the nurse's MAR (medication administration record). The CNA assists the resident and monitors intake, so dietary information should be included on the flow sheet. A check between dietary trays sent, the MAR, and the

flow sheet is prudent. Flow sheet has an adequate area under the meal intake order to enter the type of diet, food restrictions, texture, consistency, and alerts. Consolidating the meals, snacks, and specific instructions for that resident into one order block on the flow sheet decreases charting omissions.

A flow sheet safety devices, *wander guard testing every week*, is initialed every week. If another department is testing and recording, remove this order from the flow sheet. Don't leave blank sections on the sheet.

Monthly check of vital signs and weight is a POC service (Other Needs) to be provided per most residents' POCs. Weight can be insignificant unless compared to prior weights. To monitor change, the past months' weights, the current month's weight, and the difference in pounds can be recorded.

The CNA can write the weight and vital signs on the flow sheet each month, to show that the task has been completed and to view the numbers each day. If the numbers are recorded somewhere else, then change the wording to *Weight/vital signs recorded in AccuCare; changes and concerns reported to nurse,* then initial. Don't leave the flow sheet blank.

Mental status, orientation, memory, behaviors is a task listed on the POC, so include it on the flow sheet. This service is not the behavior that is monitored on the behavior log for antipsychotic drug use. It is daily mental status to which the CNA responds, with specific instructions or alerts about orientation, behavior, or memory.

Document communication between the CNAs, nurses, residents, families/POA, physicians, outside agencies, and care coordinator in the AccuCare progress notes.

Records of transportation to medical appointments are kept for at least 7 years. The Home provides the transportation or arranges the service. The record includes family or friend who was contacted, the driver, date, time, location, who the resident is visiting, and escort if needed.

Individual laundry and housekeeping (L/HK) and activities records are kept for the MW residents. Assure that the records are centrally stored and not disposed unintentionally. Again, staff initials the record each month that they provide services.

A master signature list with initials can be used in the Home for activities, laundry, and housekeeping. If 4 different staff provides activities during the month, the 4 sets of initials are written on the page, for that resident for that month. A master signature list with initials and printed names could be kept.

Activities are called socialization because they must involve at least 2 persons. And the social activity is in addition to interaction that happens during ADLs, which includes care and meals. Several attempts have been made to find a MW regulation about the extent and frequency of activities, but there are none. Medicaid says to "follow the POC" but the wording can be interpreted in different ways. There are no rigid rules about activity documentation, but Homes have been cited for lack of activity documentation.

The extent of service will be stated on the flow sheets. For example, the service is LAUNDRY, but the extent of service is wash, fold, and deliver to resident.

Regular weekly nursing progress notes are encouraged. Progress notes with status updates for Level 3 MW residents are encouraged. The standards of practice direct providers to monitor emotional, physical, psychological changes; emergency care; communication; fall prevention and response; drug monitoring/ changes/ side effects/ errors; and incident management. Charting by exception was developed 30 years ago. Today if it wasn't recorded, it wasn't done. If there is no nursing assessment, the nurse did not assess the resident.

A change is not necessarily a significant change or a level change. A progress note can affirm health status. A *no change* progress note for a Level 3 resident is meant as an occasional note, once or twice a year, not every week.

The nurse consultant is a member of the AKPH team and serves the Homes as a third party to offers recommendations.

N-15 Approved: 08/21/2013