Rosenfeld Injury Lawyers

Jonathan Rosenfeld's Nursing Homes Abuse Blog

How Accurate Are Medical Records From Nursing Homes?

By Jonathan Rosenfeld on September 23, 2011

Any environmentalist coming into my office would likely cringe at the heaps of medical records that I've accumulated from various nursing homes and hospitals on cases that I'm working on.

I've really got nothing against beautiful trees, but in order to properly review and prosecute cases, medical records remain an incredibly important piece of the puzzle in terms of evaluating cases.

After all, medical records are objectively comprised documents that reflects the care provided by staff and the patient's condition throughout their entire stay at the facility. Right?

A recent article in the Sacramento Bee, "Woman's death raises questions about nursing home medical records," identified an ongoing problem in the nursing home industry---doctored medical records. The article documents the consistent inconsistencies betwee in a patient's chart during a short-term admission at El Dorado Care Center (California), formerly part of Horizon Healthcare.

Specifically, the article referenced the negligent care and subsequent lawsuit relating to the care provided to Johnnie Esco. Like most nursing home patients, Mrs. Esco was admitted to the nursing home in order to receive medical care for several medical problems including chronic constipation.

After initiating a nursing home negligence lawsuit, the family learned that in addition to not receiving proper care, the facilities inaccurate charting likely exacerbated her decline and subsequent death.

When compared with notes compiled by family members, medical records from other facilities and testimony from staff at the facility, it was quickly revealed that nothing in Mrs. Esco's medical chart was really truthful. Discovered problems included:

- Documented assessment that were never really completed
- Rote charting- where staff filled in boxes identically to the day prior
- Late entries to the records that dramatically changed original entries
- Missing physician orders
- Drastic inconsistencies
- Fraud

What soon developed was a situation where in a mere 13 days, Mrs. Esco went from an ongoing grandmother and great-grandmother into a terminally ill woman. It turned out, that the chronic-constipation that Mrs. Esco and her family were readily controlling at home went completely unchecked and untreated during her short-term stay at El Dorado Care Center.

By the time she was transferred to a nearby hospital, Mrs. Esco had become completely bedridden and unresponsive. A bowel obstruction had left her stomach distended and

painful. The extent of the fecal impaction was so extensive that doctor's suggested that even with surgery her chances of living a quality life were minimal. On March 7, 2008 Mrs. Esco died.

Doctored Medical Record

As a nursing home lawyer, I'm always amazed at how frequently I come across inaccurate and altered medical records. Particularly in cases where a facility knows that it 'screwed up' I find especially important to secure a set of medical records as soon as feasible in order to preserve the condition of the records.

Federal law imposes a duty on nursing homes to accurately maintain patient records. Under Medicare requirements for long term care facilities, nursing facilities are required to maintain records on each resident in accordance with accepted professional standards and practice (42 CFR §483.75(l) or Tag F-514).

Pursuant to F-tag 514, nursing homes must do the following:

- Maintain complete medical charts for patients
- Accurately document treatment provided
- Make sure the records are easily accessible
- Organize patient charts