

N-03 Documentation Guidelines and Medicaid

Rules of documentation:

1. Check the page to assure the right resident and the current month.
2. Document as you go; don't wait until the end of the day to go back and record.
3. If a service is refused or the resident is unavailable, write a short note with the date.
Usually these notes are written on the back of the page.
4. Avoid using abbreviations, and keep it simple.
5. Date and initial every service that you provide; don't leave blanks unless the service was not provided.
6. Initial flow sheets on the front and sign name at the bottom of the page or on the back.
7. Use black ink on white paper; don't use a pencil or light colored pen.
8. Cross out error with a single line, so the error can still be seen. Don't erase or white-out.
9. Maintain privacy and confidentiality.

Medicaid instructs that services provided for a Medicaid waiver resident be recorded. The Homes are not required to use the same document, but the one that is chosen by the Home is:

- Organized,
- Easy to interpret,
- Quickly accessible, *and*
- Individualized (for only one resident).

Documenting a service includes:

- Resident's name,
- Date of service,
- Service provided, including the extent of the service, *and*
- Employee providing the service (initials).

In the Standards of Practice (SOP) under HCBS Monitoring Recipient Health Safety and Well-Being, it infers that a summary of the Medicaid waiver care be documented. Changes in emotional, physical, or psychological well-being, emergency response, fall prevention, medication management, critical incident review, and communication between health care providers are recorded. Weekly summaries seem adequate at this time.