Falsification of Patient Care Record Can Lead to Criminal Convictions

written by Nancy Brent | June 1, 2017

Avoiding Liability Bulletin – June 1, 2017

N.B., an LPN, worked at a nursing home and was assigned to care for J.E., a Medicaid patient who suffered from seizures, dementia with behavior disturbances, COPD, and bowel problems. He was bed ridden and "characterized as a medical and behavioral high risk" due to his many health problems.1

J.E.'s wife was not sure her husband was receiving the care and medications he was ordered to have by his physician, so she contacted the FBI and consented to have a covert video surveillance camera installed in her husband's room. The surveillance was done for 2 months.

The video of N.B.'s care of J.E. clearly showed that she did not administer some of the medications prescribed but documented them as being given. She also failed to perform nursing care she documented as being done. Vital signs were not taken but made-up results were documented. N.B. did not reposition the patient as ordered. She also fabricated several entries in his medical record.2

When the FBI showed N.B. her entries, she responded that the entries were correct.

N.B. was convicted of four counts of forgery at her trial. She appealed that judgment, alleging that the evidence upon which she was convicted was insufficient to prove intent to defraud and prejudice to another, two essential elements to prove forgery. Because her attorney was disqualified from representing her due to a conflict, N.B. alleged she was entitled to a new trial.

The Virginia Court of Appeals upheld the guilty verdict against N.B. on the four counts of forgery because the evidence at the trial level proved her guilt beyond a reasonable doubt. Moreover, the Court opined, the disqualification of N.B.'s attorney was correct and therefore no new trial was required.

The Court evaluated the applicable law in this case and N.B.'s conduct. During the trial, N.B. argued that even if she failed to accurately document what care she did or did not provide, that alone does not prove intent to defraud. She also argued that there was no proof that she "benefited" from her conduct.

The trial record below, however, indicated that N.B. made at least 50 documented false entries and therefore there was evidence of fraudulent intent. N.B.'s conduct was not an isolated event, the Appellate Court held, but was a "pattern of behavior to misrepresent the patient's treatment and medications."

As an LPN, N.B. knew of the importance of maintaining accurate documentation. Repercussions of her

inaccurate documentation clearly “prejudiced” J.E. because he did not receive important medications and treatments as ordered.

N.B’s argument that she derived no benefit from her conduct was also struck down by the Court. To begin with, she was paid for the time she worked at the nursing home and also benefited from “masking her dereliction” of her duties to the patient.

The Court also discussed the fact that what appears in a patient’s records determines the level of Medicaid reimbursement. As a result, Medicaid was also prejudiced by N.B.’s documentation of care and medications given but not provided.

Along a similar vein, the nursing home was also prejudiced by N.B. not accurately documenting in the patient’s record. It was prejudiced in that her conduct could result in civil penalties, loss of licensure, or closure of the facility.3

N.B.’s argument as to the disqualification of her attorney was also struck down by the Court.

This case is one that bears remembering. Falsification in any record in connection with your nursing practice is unethical and violates many laws. N.B. is now a convicted felon who will most likely be unable to work in the health care field again due to the nature and the numerous incidents of her falsified entries.

The state nurse practice act is another area of liability. N.B. will most probably be required to appear before the board of nursing due to the criminal conviction. In addition, there may be grounds for violating the act or rules itself due to the numerous falsifications in the patient’s record and the non-care she had a duty to provide. Due to this conduct, she could be disciplined by the board, which could include a revocation of her license.

Another interesting point of this case bears underscoring as well. N.B.’s attorney also represented five other indicted employees at the nursing home surrounding the care of J.E. Two of those other employees were granted a plea deal if they cooperated with the prosecution and testified against N.B. and several other staff. Another was granted immunity if he testified against the others. This employees accepted the offer and were willing to testify against N.B.

So, the bottom line from this case is to document honestly, accurately, and completely and to provide the care you are required to provide to your patients.

The video surveillance is this case, along with the forged documentation, helped provide evidence beyond a reasonable doubt of N.B.’s guilt. Although you may never experience being filmed while you provide care, other means exist to prove whether nursing care was provided.

One sure way is when those with whom you work are more than willing to provide whatever details necessary– truthful or otherwise– to maintain their nursing career at the expense of sacrificing yours.

Don’t give them an opportunity to do so.

FOOTNOTES

1. Beshah v. Commonwealth, 725 S.E. 2d 144 (2012), 144.
2. Id., at 145.
3. “Forgery: Nurse Convicted For Falsifying Nursing Documentation” (June 2012), Legal Eagle Eye Newsletter For The Nursing Profession, 4.