



Fall Prevention Program for Skilled Nursing Facilities

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Fall Prevention Program

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F689

Quality of Care

§483.25(d)(1)(2)

Free of Accident Hazards/Supervision/Devices

Survey Regulations & Interpretive Guidelines

F689

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(d) Accidents.

The facility must ensure that –

§483.25(d)(1) *The resident environment remains as free of accident hazards as is possible; and*

§483.25(d)(2) *Each resident receives adequate supervision and assistance devices to prevent accidents.*

INTENT: §483.25(d)

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- *Identifying hazard(s) and risk(s);*
- *Evaluating and analyzing hazard(s) and risk(s);*
- *Implementing interventions to reduce hazard(s) and risk(s); and*
- *Monitoring for effectiveness and modifying interventions when necessary.*

DEFINITIONS §483.25(d)

Definitions are provided to clarify terms related to providing supervision and other interventions to prevent accidents.

*“**Accident**” refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reaction).*

*“**Avoidable Accident**” means that an accident occurred because the facility failed to:*

- *Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or*
- *Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or*
- *Implement interventions, including adequate supervision and assistive devices, consistent with a resident’s needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or*
- *Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.*

“Unavoidable Accident” means that an accident occurred despite sufficient and comprehensive facility systems designed and implemented to:

- Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and
- Evaluate/analyze the hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible;
- Implement interventions, including adequate supervision, consistent with the resident’s needs, goals, care plan, and current professional standards of practice in order to eliminate or reduce the risk of an accident; and
- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current professional standards of practice.

“Assistance Device or Assistive Device” refers to any item (e.g., fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand- alone or overhead transfer lifts, canes, wheelchairs, and walkers, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident’s function and/or safety.

NOTE: The currently accepted nomenclature refers to “assistive devices.” Although the term “assistance devices” is used in the regulation, the Guidance provided in this document will refer to “assistive devices.”

“Environment” refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents’ rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.

“Fall” refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred (refer to Resident Assessment Instrument User’s Manual, Version 3.0, Chapter 3, page J-27).

“Hazards” refer to elements of the resident environment that have the potential to cause injury or illness.

- “Hazards over which the facility has control” are those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness.
- “Free of accident hazards as is possible” refers to being free of accident hazards over which the facility has control.

“Position change alarms” are alerting devices intended to monitor a resident’s movement. The devices emit an audible signal when the resident moves in a certain way. Types of position

change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors.⁷ Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.

“Risk” refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.

“Supervision/Adequate Supervision” refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

GUIDANCE §483.25(d)

OVERVIEW

Numerous and varied accident hazards exist in everyday life. Not all accidents are avoidable. The frailty of some residents increases their vulnerability to hazards in the resident environment and can result in life-threatening injuries. It is important that all facility staff understand the facility's responsibility, as well as their own, to ensure the safest environment possible for residents.

The facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting residents' rights to privacy, dignity and self-determination, and their right to make choices about significant aspects of their life in the facility.

An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. A facility with a commitment to safety:

- *Acknowledges the high-risk nature of its population and setting;*
- *Develops effective communication, including a reporting system that does not place blame on the staff member for reporting resident risks and environmental hazards;*
- *Engages all staff, residents and families in training on safety, and promotes ongoing discussions about safety with input from staff at all levels of the organization, as well as residents and families;*
- *Encourages the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise;*
- *Directs resources to address safety concerns; and*
- *Demonstrates a commitment to safety at all levels of the organization.*

⁷ Bressler, K., Redfern, R.E., and Brown, M.(2011). Elimination of position-change alarms in an Alzheimer's and dementia long-term care facility. *Am J Alzheimers Dis Other Demen* 26(8), 599.

A SYSTEMS APPROACH

Processes in a facility's interdisciplinary systematic approach may include:

- *Identification of hazards, including inadequate supervision, and a resident's risks of potentially avoidable accidents in the resident environment;*
- *Evaluation and analysis of hazards and risks;*
- *Implementation of individualized, resident-centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment; and*
- *Monitoring for effectiveness and modification of interventions when necessary.*

A key element of a systematic approach is the consistent application of a process to address identified hazards and/or risks. Risks may pertain to individual residents, groups of residents, or the entire facility. Hazards may include, but are not limited to, aspects of the physical plant, equipment, and devices that are defective or are not used properly (per manufacturer's specifications), are disabled/removed, or are not individually adapted or fitted to the resident's needs.

- *An effective system not only proactively identifies environmental hazards and the resident's risk for an avoidable accident, but also evaluates the resident's need for supervision.*

Identifying and addressing risks, including the potential for accidents, includes consideration of the environment, the resident's risk factors, and the need for supervision, care, and assistive devices. This will allow the facility to communicate information about observed hazards, identify resident-specific information, develop and implement an individualized care plan based on the Resident Assessment Instrument (RAI) to address each resident's needs and goals, and to monitor the results of the planned interventions. The care plan should strive to balance the resident's wishes with the potential impact on other residents.

A systematic approach enables the facility to evaluate safety throughout its environment and among all staff, and make appropriate adjustments in training and competency testing as required. Each resident or representative and their family members and representatives should be aware of the risks and potential hazards related to falls and of various devices used to reduce fall risk. Furthermore, a systematic approach enables leadership and direct care staff to work together to revise policies and procedures, based on feedback from workers who are most familiar with the residents and care processes. Effective facility systems address how to:

- *communicate the observations of hazards,*
- *record resident specific information, and*
- *monitor data related to care processes that potentially lead to accidents.*

Identification of Hazards and Risks

Identification of hazards and risks is the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. Various sources provide

information about hazards and risks in the resident environment. These sources may include, but are not limited to, Quality Assessment and Assurance (QAA) activities, environmental rounds, MDS/CAAs data, medical history and physical exam, facility assessment as required in F838, and individual observation. This information is to be documented and communicated across all disciplines.

Evaluation and Analysis

Evaluation and analysis is the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc.

Both the facility-centered and resident-directed approaches include evaluating hazards and accident risk data which includes prior accidents/incidents, analysis to identify the root causes of each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. Evaluations also look at trends such as time of day, location, etc.

Implementation of Interventions

Implementation refers to using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: Communicating the interventions to all relevant staff, assigning responsibility, providing training as needed, documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident), and ensuring that the interventions are put into action.

Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with professional standards, including evidence-based practice. Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully.

Facility-based interventions may include, but are not limited to, educating staff, repairing the device/equipment, and developing or revising policies and procedures. Resident-directed approaches may include implementing specific interventions as part of the plan of care, supervising staff and residents, etc. Facility records document the implementation of these interventions.

Monitoring and Modification

Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks.

Monitoring and modification processes include:

- *Ensuring that interventions are implemented correctly and consistently;*
- *Evaluating the effectiveness of interventions;*
- *Modifying or replacing interventions as needed and*

- *Evaluating the effectiveness of new interventions.*

An example of facility-specific modification is additional training of staff when equipment has been upgraded, while a resident-specific modification is revising the care plan to reflect the resident's current condition and risk factors that may have changed since the previous assessment.

For example, a facility implements a position change alarm for a newly admitted resident with a history of falls. After completing a comprehensive assessment of the resident, facility staff identify the resident's routines and patterns, remove the alarm, implementing more individualized interventions that address the actual cause of why a resident may be changing position (e.g. has been in one position too long or is trying to reach for a personal item) which could lead to a fall.

Supervision

Supervision is an intervention and a means of mitigating accident risk. Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Devices such as position change alarms may help to monitor a resident's movement temporarily, but do not eliminate the need for adequate supervision.

The resident environment may contain temporary hazards (e.g., construction, painting, housekeeping activities, etc.) that warrant additional supervision or alternative measures such as barriers to prevent access to affected areas of the resident environment.

Adequate supervision to prevent accidents is enhanced when the facility:

- *Accurately assesses a resident and/or the resident environment to determine whether supervision to avoid an accident is necessary; and/or*
- *Determines that supervision of the resident was necessary and provides supervision based on the individual resident's assessed needs and the risks identified in the environment.*

Resident Smoking

Some facilities permit residents to smoke tobacco products. In these facilities, assessment of the resident's capabilities and deficits determines whether or not supervision is required. If the facility identifies that the resident needs assistance and supervision for smoking, the facility includes this information in the resident's care plan, and reviews and revises the plan periodically as needed.

The facility may designate certain areas for resident smoking. The facility must ensure precautions are taken for the resident's individual safety, as well as the safety of others in the facility. Such precautions may include smoking only in designated areas, supervising residents whose assessment and care plans indicate a need for assisted and supervised smoking, and limiting the accessibility of matches and lighters by residents who need supervision when smoking for safety reasons. Smoking by residents when oxygen is in use is prohibited, and any

smoking by others near flammable substances is also problematic. Additional measures may include informing all visitors of smoking policies and hazards.

Guidance concerning resident smoking regulations can be found in NFPA 101, the Life Safety Code at 19.7.4, Smoking, including requirements for signage, prohibiting smoking by residents classified as not responsible, and disposal of smoking materials.

Resident-to-Resident Altercations

NOTE: *A resident to resident altercation should be reviewed as a potential situation of abuse which should be investigated under the guidance for 42 CFR §483.12, (F600). The surveyor should not automatically assume that abuse did not occur for a resident identified as having a cognitive impairment or mental disorder, as it does not preclude the resident from deliberate (willful) or non-accidental actions. “Willful” as defined at §483.5 and as used in the definition of “abuse,” “means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.” Even though a resident may have a cognitive impairment, he/she could still commit a willful act. If during the investigation of an allegation of abuse, it is determined that the action was not willful, the surveyor must investigate whether the facility is in compliance with the requirement to maintain an environment as free of accident hazards as possible, and that each resident receives adequate supervision using guidance at this tag, F689, Accidents.*

It is important that a facility take reasonable precautions, including providing adequate supervision, when the risk of resident-to-resident altercation is identified, or should have been identified. Certain situations or conditions may increase the potential for such altercations, including, but not limited to:

- A history of aggressive behaviors including striking out, verbal outbursts, or negative interactions with other resident(s); and/or*
- Behavior that may disrupt or annoy others such as constant verbalization (e.g., crying, yelling, calling out for help), making negative remarks, restlessness, repetitive behaviors, taking items that do not belong to them, going into others’ rooms, drawers, or closets, and undressing in inappropriate areas. Although these behaviors may not be aggressive in nature, they may precipitate a negative response from others, resulting in verbal, physical, and/or emotional harm.*

The facility is responsible for identifying residents who have a history of disruptive or intrusive interactions, or who exhibit other behaviors that make them more likely to be involved in an altercation. The facility should identify the factors (e.g., pain, specific triggers in the environment, etc.) that increase the risks associated with individual residents, including those that could trigger an altercation. The interdisciplinary team reviews the assessment along with the resident and/or his/her representative, in order to address the underlying reasons for the behavioral manifestations and to identify interventions to try to prevent altercations.

The interventions listed below include supervision and other actions that could address potential or actual negative interactions:

- *Evaluating staffing levels to ensure adequate supervision (if it is adequate, it is meeting the resident's needs) (refer to F725, §483.35(a)(1)(2), to evaluate staffing levels for any nursing services not related to behavioral health care or dementia care and F741, §483.40, for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder);*
- *Evaluating staffing assignments to ensure consistent staff who are more familiar with the resident and who thus may be able to identify changes in a resident's condition and behavior;*
- *Providing safe supervised areas for unrestricted movement;*
- *Eliminating or reducing underlying causes of distressed behavior such as boredom and pain;*
- *Monitoring environmental influences such as temperatures, lighting, and noise levels; and*

Ongoing staff training, competencies and supervision, including how to approach a resident who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms (refer to F726, §483.35(a)(3)(4)(c), to evaluate staff competency for any nursing services not related to behavioral health care or dementia care and F741, §483.40, for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder).

RISKS AND ENVIRONMENTAL HAZARDS

This section discusses common, but not all, potential risks and hazards found in the resident environment.

NOTE: *The information included in the following sections is based on current professional standards of practice or "best practice" models as described in the literature.*

The physical plant, devices, and equipment described in this section may not be hazards by themselves but can become hazardous when a vulnerable resident interacts with them. Some temporary hazards in the resident environment can affect most residents who have access to them (e.g., construction, painting, and housekeeping activities). Other situations may be hazardous only for certain individuals (e.g., accessible smoking materials).

In order to be considered hazardous, an element of the resident environment must be accessible to a vulnerable resident. Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities, mood, and health treatments (e.g., medications). Resident vulnerability to hazards may change over time. Ongoing assessment helps identify when elements in the environment pose hazards to a particular resident.

Certain sharp items, such as scissors, kitchen utensils, knitting needles, or other items, may be appropriate for many residents but hazardous for others with cognitive impairments. Handrails, assistive devices, and any surface that a resident may come in contact with may cause injury, if the surface is not in good condition, free from sharp edges or other hazards or not installed properly.

Improper actions or omissions by staff can create hazards in the physical plant (e.g., building and grounds), environment, and/or with devices and equipment. Examples of such hazards might include fire doors that have been propped open, disabled locks or latches, nonfunctioning alarms, buckled or badly torn carpets, cords on floors, irregular walking surfaces, improper storage and access to toxic chemicals, exposure to unsafe heating unit surfaces, and unsafe water temperatures. Other potential hazards may include furniture that is not appropriate for a resident (e.g., chairs or beds that are not the proper height or width for the resident to transfer to and from safely or unstable as to present a fall hazard) and lighting that is either inadequate or so intense as to create glare. Devices for resident care, such as pumps, ventilators, and assistive devices, may be hazardous when they are defective, disabled, or improperly used (i.e., used in a manner that is not per manufacturer's recommendations or current professional standards of practice).

Resident Vulnerabilities

*The responsibility to respect a resident's choices is balanced by considering the resident's right to direct the care they receive with the potential impact of these choices on their well-being, other residents, and on the facility's obligation to protect residents from harm. The facility has a responsibility to educate a resident, family, and staff regarding significant risks related to a resident's choices. When a resident choice poses some risk, staff should work with the resident to understand reasons for the choice, and discuss options for the facility to honor the choice. For example, a resident may express a desire to use a cane instead of a walker or wheelchair in order to maintain dignity and self-esteem. This preference should be discussed to review potential positive and negative consequences of possible courses of action (including potential negative consequences that may result from preventing the choice) and to find ways to develop a care plan in which staff honor the choice while mitigating risks. For more information on care planning to mitigate risk, see *A Process for Care Planning Resident Choice* at http://www.ideasinstitute.org/PDFs/Process_for_Care_Planning_for_Residnet_Choice.pdf.*

Verbal consent or signed consent/waiver forms do not eliminate a facility's responsibility to protect a resident from an avoidable accident, nor does it relieve the provider of its responsibility to assure the health, safety, and welfare of its residents. While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. The regulations hold the facility ultimately accountable for the resident's care and safety.

Falls and unsafe wandering/elopement are of particular concern. The following section reviews these issues along with some common potential hazards.

Falls - *The MDS defines a fall as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.*

NOTE: Challenging a resident's balance and training him/her to recover from loss of balance is an intentional therapeutic intervention. The losses of balance that occur during supervised therapeutic interventions are not considered a fall.

Some factors that may result in resident falls include, but are not limited to:

- Environmental hazards, such as wet floors, poor lighting, incorrect bed height and/or width, or improperly fitted or maintained wheelchairs;⁸
- Unsafe or absent footwear;
- Underlying chronic medical conditions, such as arthritis, heart failure, anemia and neurological disorders;
- Acute change in condition such as fever, infection, delirium;
- Medication side effects;
- Orthostatic hypotension;
- Lower extremity weakness;
- Balance disorders;
- Poor grip strength;
- Functional impairments (difficulty rising from a chair, getting on or off toilet, etc.);
- Gait disorders;
- Cognitive impairment;
- Visual deficits;
- Pain; and
- Incontinence.

Muscle weakness and gait problems account for about 24% of nursing home falls and environmental hazards cause 16% to 27% of falls for residents.⁹

Older persons have both a high incidence of falls and a high susceptibility to injury.¹⁰ Serious potential consequences of falls include physical injuries, pain, increased risk of death, impaired function, fear of falling, and self-imposed limitations on activities leading to social isolation.¹¹ Evaluation of all of the causal factors leading to a resident fall assists the facility in developing and implementing relevant, consistent, and individualized interventions to prevent future occurrences. Proper actions following a fall include:

- Ascertaining if there were injuries, and providing treatment as necessary;

8 Shorr, R.I., Chandler, M., Mion, L.C., Waters, T.M., Liu, M., Daniels, M.J., Kessler, L.A., and Miller, S.T. (2012). Effects of an intervention to increase bed alarm use to prevent falls in hospitalized patients. *Annals of Internal Medicine* 157(10), 698.

9 The Centers for Disease Control and Prevention. Falls in Nursing Homes. <http://www.cdc.gov/homeandrecreationalafety/falls/nursing.html>.

10 Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics. (2010). Summary of the updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. *J Am Geriatr Soc*, 2011, 59(1), 148-57.

11 Taylor, J.A., Parmelee, P., Brown, H., and Ouslander, J. *The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities*. Agency for Healthcare Research and Quality, 2005, <http://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspix/fallspixmanual.html>.

- *Determining what may have caused or contributed to the fall, including ascertaining what the resident was trying to do before he or she fell;*
- *Addressing the risk factors for the fall such as the resident’s medical conditions(s), facility environment issues, or staffing issues; and*
- *Revising the resident’s plan of care and/or facility practices, as needed, to reduce the likelihood of another fall.*

NOTE: *A fall by a resident does not necessarily indicate a deficient practice because not every fall can be avoided.*

Position Change Alarms:

Facilities often implement position change alarms as a fall prevention strategy or in response to a resident fall. The alarms are designed to alert staff that the resident has changed position, increasing the risk for falling. However, the efficacy of alarms to prevent falls has not been proven and a study of hospitalized patients concluded these devices may only alert staff that a fall has already occurred. The same study also noted false alarms are a common problem leading to “alarm fatigue,” where staff no longer respond to the sound of an alarm.¹² A study on bed-exit alarms concluded the alarms are not a substitute for staff assisting residents and bed-exit alarms may not always function reliably for residents who weigh less than 100 pounds or who are restless.¹³ Individual facility efforts to reduce use of alarms have shown falls actually decrease when alarms are eliminated and replaced with other interventions such as purposeful checks to proactively address resident needs, adjusting staff to cover times of day when most falls occur, assessing resident routines, and making individualized environmental or care changes that suit each resident.¹⁴ For example, brighter lighting might help a resident with macular degeneration ambulate more easily in his or her room but would cause glare and make walking more difficult for a resident with cataracts.¹⁵

Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls. While position change alarms are not prohibited from being included as part of a plan, they should not be the primary or sole intervention to prevent falls. If facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident. Use of these devices, like any care planning intervention, must be based on assessment of the resident and monitored for efficacy on an on-going basis. Position change alarms have been used to monitor a resident’s movement in chairs or beds, etc. However, there must be sufficient staff and supervision to meet the resident’s needs and staff must be vigilant in order to respond to alarms a timely manner. Alarms do not replace necessary supervision. Facilities must take steps to identify issues that place the resident at risk for falls and implement approaches to address those

12 Shorr, R.I., Chandler, M., Mion, L.C., Waters, T.M., Liu, M., Daniels, M.J., Kessler, L.A., and Miller, S.T. (2012). Effects of an intervention to increase bed alarm use to prevent falls in hospitalized patients. Annals of Internal Medicine 157(10), 698.

13 Capezuti, E., Brush, B.L., Lane, S., Rabinowitz, H.U., and Secic, M. (2009). Bed-exit alarm effectiveness. Arch Gerontol Geriatr 49(1) 27-31.

14 MASSPRO (n.d.). Nursing home alarm elimination program: It’s possible to reduce falls by eliminating resident alarms. <http://www.masspro.org/case-studies/elimalarmsrehab.pdf>.

15 Becker, C., Rapp, K. (2010) Fall Prevention in Nursing Homes. Clinics in Geriatric Medicine 26(4)693-704.

risks in a manner that enables the resident to achieve or maintain his or her highest practicable physical, mental, and psychosocial well-being.

Wandering and Elopement - *Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the facility aimlessly may indicate that the resident is frustrated, anxious, bored, hungry, or depressed. Goal-directed wandering may fulfill a resident's need for exercise or provide sensory stimulation. This goal directed wandering should also require staff supervision and a facility response to address safety issues.*

Wandering may become unsafe when a resident becomes overly tired or enters an area that is physically hazardous or that contains potential safety hazards (e.g., chemicals, tools, and equipment, etc.). Entering into another resident's room may lead to an altercation or contact with hazardous items.¹⁶ Unsafe wandering can be associated with an increased risk for falls and injuries.

While wander, door, or building alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision, and require scheduled maintenance and testing to ensure proper functioning.

Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident.

Physical Plant Hazards

NOTE: *Refer to guidance at §483.70(e) (F838) for facility responsibilities regarding the facility's physical environment.*

Supervision and/or containment of hazards are needed to protect residents from harm caused by environmental hazards. Examples of such hazards can range from common chemical cleaning materials to those caused by adverse water temperatures or improper use of electrical devices.

Chemicals and Toxins - *Various materials in the resident environment can pose a potential hazard to residents. Hazardous materials can be found in the form of solids, liquids, gases,*

¹⁶ Boltz, M. (2003). *Litigation Issues Related To Wandering and Elopement*. The John A. Hartford Foundation Institute for Geriatric Nursing, New York University, The Steinhardt School of Education, Division of Nursing. Retrieved May 9, 2014 from <http://www.nccdp.org/wandering.htm>.

mists, dusts, fumes, and vapors. The routes of exposure for toxic materials may include inhalation, absorption, or ingestion.

For a material to pose a safety hazard to a resident, it must be toxic, caustic, or allergenic; accessible and available in a sufficient amount to cause harm. Toxic materials that may be present in the resident environment are unlikely to pose a hazard unless residents have access or are exposed to them. Some materials that would be considered harmless when used as designed could pose a hazard to a resident who accidentally ingests or makes contact with them.

Examples of materials that may pose a hazard to a resident include (but are not limited to):

- Chemicals used by the facility staff in the course of their duties (e.g., housekeeping chemicals) and chemicals or other materials brought into the resident environment by staff, other residents, or visitors;*
- Drugs and therapeutic agents;*
- Plants and other “natural” materials found in the resident environment or in the outdoor environment (e.g., poison ivy).*

One source of information concerning the hazards of a material that a facility may obtain is the Material Safety Data Sheet (MSDS).¹⁷ The Occupational Safety and Health Administration (OSHA) requires employers to have a MSDS available for all hazardous materials that staff use while performing their duties.¹⁸ MSDSs are available on-line for numerous chemicals and non-toxic materials, and should be reviewed carefully to determine if the material is toxic and poses a hazard. Poison control centers are another source of information for potential hazards, including non-chemical hazards such as plants.

NOTE: *Toxicological profiles for a limited number of hazardous materials are accessible on the Agency for Toxic Substances & Disease Registry Web site at <http://www.atsdr.cdc.gov/>.*

Water Temperature - *Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate.¹⁹*

The degree of injury depends on factors including the water temperature, the amount of skin exposed, and the duration of exposure. Some States have regulations regarding allowable maximum water temperature. Table 1 illustrates damage to skin in relation to the temperature of the water and the length of time of exposure.²⁰

¹⁷ Agency for Toxic Substances & Disease Registry web site at <http://www.atsdr.cdc.gov/toxprofiles/index.asp>.

¹⁸ US Dept. of Labor, Occupational Safety and Health Standards, 29 CFR 1910.1200 (g)(1) and (2).

¹⁹ Katcher, L.K. (1981). Scald Burns from Hot Tap Water. *Journal of Am Med Assoc.*, 246(11), 1219-1222.

²⁰ Moritz, A.R., Henriques F.C. Jr. (1947). Studies of Thermal Injury: II. The Relative Importance of Time and Surface Temperatures in the Causation of Cutaneous Burns. *Am J Pathology*, 23, 695-720.

Table 1. Time and Temperature Relationship to Serious Burns

<i>Water Temperature</i>		<i>Time Required for a 3rd Degree Burn to Occur</i>
<i>155°F</i>	<i>68°C</i>	<i>1 sec</i>
<i>148°F</i>	<i>64°C</i>	<i>2 sec</i>
<i>140°F</i>	<i>60°C</i>	<i>5 sec</i>
<i>133°F</i>	<i>56°C</i>	<i>15 sec</i>
<i>127°F</i>	<i>52°C</i>	<i>1 min</i>
<i>124°F</i>	<i>51°C</i>	<i>3 min</i>
<i>120°F</i>	<i>48°C</i>	<i>5 min</i>
<i>100°F</i>	<i>37°C</i>	<i>Safe Temperatures for Bathing (see Note)</i>

NOTE: Burns can occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure.

Based upon the time of the exposure and the temperature of the water, the severity of the harm to the skin is identified by the degree of burn, as follows.²¹

- First-degree burns involve the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling.
- Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin.
- Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black.

Electrical Safety - Any electrical device, whether or not it needs to be plugged into an electric outlet, can become hazardous to the residents through improper use or improper maintenance. Electrical equipment such as electrical cords can become tripping hazards. Halogen lamps or heat lamps can cause burns or fires if not properly installed away from combustibles in the resident environment. The Life Safety Code prohibits the use of portable electrical space heaters in resident areas.

Extension cords should not be used to take the place of adequate wiring in a facility. If extension cords are used, the cords should be properly secured and not be placed overhead, under carpets or rugs, or anywhere that the cord can cause trips, falls, or overheat. Extension cords should be connected to only one device to prevent overloading of the circuit. The cord itself should be of a size and type for the expected electrical load and made of material that will not fray or cut

²¹ US Dept. of Health and Human Services. Centers for Disease Control and Prevention. Emergency Preparedness & Response. Mass Casualties: Burns. Retrieved March 25, 2014 from <http://www.bt.cdc.gov/masscasualties/burns.asp>

easily. Electrical cords including extension cords should have proper grounding if required and should not have any grounding devices removed or not used if required.

Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor, and printer. Power strips are not designed to be used with medical devices in patient care areas. Precautions needed if power strips are used include: installing internal ground fault and over-current protection devices; preventing cords from becoming tripping hazards; and using power strips that are adequate for the number and types of devices used. Overload on any circuit can potentially cause overheating and fire. The use of ground fault circuit interruption (GFCIs) may be required in locations near water sources to prevent electrocution of staff or residents.²²

The proper use of electric blankets and heating pads is essential to avoid thermal injuries. These items should not be tucked in or squeezed. Constriction can cause the internal wires to break. A resident should not go to sleep with an electric blanket or heating pad turned on. Manufacturer's instructions for use should be followed closely. Injuries and deaths have been related to burns and fires related to the use of heating pads. Most deaths are attributable to heating pads that generated fires, but most injuries are burns from prolonged use or inappropriate temperature setting. Prolonged use on one area of the body can cause a severe burn, even when the heating pad is at a low temperature setting.²³

Lighting - *The risk of an accident increases when there is insufficient light or too much light, which often results in glare. Vision among older persons varies widely; therefore, no single level of illumination can ensure safety for all residents. The proper amount of light depends on the resident's visual needs and the task he/she is performing. An older person typically needs more light to see. However, a resident with cataracts or glaucoma may be overly sensitive to bright light, and excessive lighting could make it more difficult to see clearly and thereby increase his/her fall risk.²⁴ Creating transitional zones between light and dark spaces helps to improve sight recovery and enable safer mobility. Providing extra visual cues that clearly define needed items or spaces in areas with limited or variable light can help to enable safe performance of tasks (e.g., turning on a light). Providing supplemental light near beds for patients who are mobile may assist in safe mobility at night.²⁵*

NOTE: *Refer to guidance for 42 CFR §483.10(i)(5), F584 for lighting issues related to Resident Rights regarding adequate and comfortable lighting.*

²² Electrical Safety Foundation International Resource Library. Retrieved March 25, 2014 from <http://www.esfi.org/index.cfm/page/Resource-Library/pid/10272>.

²³ US Dept. of Health and Human Services. Food and Drug Administration. (December 12, 1995). Public Health Advisory: Hazards Associated with the Use of Electric Heating Pads. <http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/PublicHealthNotifications/ucm242866.htm>.

²⁴ Tideiksaar, R. (1998). *Falls in Older Persons: Prevention and Management* (2nd Edition). Baltimore, MD: Health Profession Press.

²⁵ Warren, M. (2001), *Occupational Therapy Practice Guidelines for Adults with Low Vision*, The American Occupational Therapy Association, Inc.

Assistive Devices/Equipment Hazards

Assistive devices also can help to prevent accidents. Assistive devices and equipment can help residents move with increased independence, transfer with greater comfort, and feel physically more secure. However, there are risks associated with the use of such devices and equipment, particularly if or when they are not properly maintained and these risks need to be balanced with the benefits gained from their use. Training of staff, residents, family members and volunteers on the proper use of assistive devices/equipment is crucial to prevent accidents. It is also important to communicate clearly the approaches identified in the care plan to all staff, including temporary staff. It is important to train staff regarding resident assessment, safe transfer techniques, and the proper use of mechanical lifts including device weight limitations.

NOTE: *The Safe Medical Devices Act of 1990 (SMDA) requires hospitals, nursing homes, and other user facilities to report deaths, serious illnesses, and injuries associated with the use of medical devices to manufacturers and the Food and Drug Administration.*

Assistive Devices for Mobility - Mobility devices include all types of assistive devices, such as, but not limited to, canes, standard and rolling walkers, manual or non-powered wheelchairs, and powered wheelchairs. Three primary factors that may be associated with an increased accident risk related to the use of assistive devices include:

- 1. Resident Condition. Lower extremity weakness, gait disturbances, decreased range of motion, and poor balance may affect some residents. These conditions combined with cognitive impairment can increase the accident risks of using mobility devices. Unsafe behavior, such as failure to lock wheelchair brakes and trying to stand or transfer from a wheelchair unsafely, can result in falls and related injuries;*
- 2. Personal Fit and Device Condition. Devices can pose a hazard if not fitted and/or maintained properly.²⁶ Personal fit, or how well the assistive device meets the individual needs of the resident, may influence the likelihood of an avoidable accident; and*
- 3. Staff Practices. Mobility devices that a resident cannot readily reach may create a hazardous situation. Unsafe transfer technique used by staff may result in an accident. Inadequate supervision by staff of a resident during the initial trial period of assistive device use or after a change in the resident's functional status can increase the risk of falls and/or injury. Additionally, staff needs to ensure assistive devices properly fit the resident and the resident has received proper training in the use of the assistive device.*

Assistive Devices for Transfer - Mechanical assistive devices for transfer include, but are not limited to, portable and stationary total body lifts, sit-to-stand devices, and transfer or gait belts. The resident assessment helps to determine the resident's degree of mobility and physical impairment and the proper transfer method; for example, whether one or more caregivers or a mechanical device is needed for a safe transfer. Residents who become frightened during transfer in a mechanical lift may exhibit resistance movements that can result in avoidable accidents. Communicating with the resident and addressing the resident's fear may reduce the risk.

²⁶ Taylor, J.A., Brown, A.K., Meredith, S., Ray, W.A. (2002). *The fall reduction program: a comprehensive program for reduction of falls and injuries in long-term care residents.* Nashville, TN: Department of Preventive Medicine, Vanderbilt University School of Medicine.

Factors that may influence a resident's risk of accident during transfer include staff availability, resident abilities, staff training and competency. The resident's ability to communicate and identify physical limitations or to aid in the transfer will help determine the need for an assistive device, such as a mechanical lift. The Occupational Safety and Health Administration (OSHA) provides information and guidelines on identifying problems and implementing solutions relating to handling residents during transfers.²⁷

Devices Associated with Entrapment Risks - Devices can be therapeutic and beneficial; however, devices are not necessarily risk free so it is important to weigh the relative risks and benefits of using certain devices. For example, while physical restraints may be used to treat a resident's medical symptom, the devices may create a risk for entrapment. Physical restraints are defined as any manual method, physical or mechanical device/equipment or material that meets all of the following criteria:

- Is attached or adjacent to a resident's body;*
- Cannot be removed easily by the resident; and*
- Restricts the resident's freedom of movement or normal access to his/her body.*

In 1992, the Food and Drug Administration (FDA) issued a Safety Alert entitled "Potential Hazards with Restraint Devices".²⁸ Serious injuries, as well as death, have been reported as a result of using physical restraints. Some physical restraints carry a risk of severe injury, strangulation, and asphyxiation. Restrained residents may be injured or die when they try to remove restraints, to ambulate while restrained, or due to an improperly fitted or used device.

Regardless of the purpose for use, bed rails (also referred to as "side rails," "bed side rails," and "safety rails") and other bed accessories (e.g. transfer bar, bed enclosures), while assisting with transfer and positioning, can increase resident safety risk. Bed rails include rails of various sizes (e.g., full length rails, half rails, quarter rails) that may be positioned in various locations on the bed. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. that may cause them to move about the bed or try to exit from the bed. The timeliness of assistance in using the bathroom, appropriateness of positioning, and other care-related activities can contribute to the risk of entrapment. The FDA provides detailed information about bed rails, including recommendations for health care providers.²⁹

Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Technical issues, such as the proper sizing of mattresses, fit and integrity of bed rails

*27 US Department of Labor, , Occupational Safety & Health Administration. Guidelines for Nursing Homes (Revised March 2009),
https://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html.*

28 US Dept. of Health and Human Services. Food and Drug Administration. (July 15, 1992). FDA Safety Alert: Potential Hazards with Restraint Devices.

*29 US Dept. of Health and Human Services. Food and Drug Administration, Bed Rail Safety,
<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm123676.htm>.*

or other design elements (e.g., wide spaces between bars in the bed rails) can also affect the risk of resident entrapment.³⁰

NOTE: §483.25(n) (F700) requires that facilities attempt appropriate alternatives before installing bed rails. Refer to §483.90(d)(3) (F909) for guidance regarding inspection and maintenance issues related to bed rails.

The use of a specialty air-filled mattress or a therapeutic air-filled bed may also present an entrapment risk that is different from rail entrapment with a regular mattress. The high compressibility of an air-filled mattress compared to a regular conventional mattress requires appropriate precautions when used for a resident at risk for entrapment. An air-filled mattress compresses on the side to which a person moves, thus raising the center of the mattress and lowering the side. This may make it easier for a resident to slide off the mattress or against the rail. Mattress compression widens the space between the mattress and rail. When a resident is between the mattress and rail, the mattress can re-expand and press the chest, neck, or head against the rail. While using air therapy to prevent and treat pressure ulcer/injuries, facilities should also take precautions to reduce the risk of entrapment. Precautions may include following manufacturer equipment alerts and increasing supervision.³¹

NOTE: §483.12 (F604), applies to the use of physical restraints. §483.25(d), This tag, F689, applies to assistive devices that create hazards (e.g., devices that are defective; not used properly or according to manufacturer's specifications; disabled or removed; not provided or do not meet the resident's needs (poor fit or not adapted); and/or used without adequate supervision when required). §483.25(n) (F700) applies to the installation of bed rails.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F689, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- Identify and eliminate all known and foreseeable accident hazards in the resident's environment, to the extent possible; or
- To the extent possible, reduce the risk of all known or foreseeable accident hazards that cannot be eliminated; or
- Provide appropriate and sufficient supervision to each resident to prevent an avoidable accident; or
- Provide assistance devices necessary to prevent an avoidable accident from occurring.

³⁰ US Dept. of Health and Human Services, Food and Drug Administration, Recommendations for Consumers and Caregivers about Bed Rails.
<http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362843.htm>.

³¹ Miles, S. (June 2002). Death between bedrails and air pressured mattresses. *J Am Geriatr Soc*, 50(6), 1124-50(6), 1124-5..

INVESTIGATIVE SUMMARY

Use

Use the Accidents Critical Element (CE) Pathway along with the above interpretive guidelines when determining if the facility meets the requirements to ensure that the resident's environment remains as free from accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents.

Summary of Accident and Supervision Investigative Procedure

Observe the general environment of the facility to determine if the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. During observation of the facility, the survey team should observe the environment for the presence of potential/actual hazards. For a resident with an identified concern, briefly review the assessment and plan of care to determine whether the facility identified resident risks and implemented interventions as necessary.

If the resident has been in the facility for less than 14 days (before completion of all the Resident Assessment Instrument (RAI) is required), review the baseline careplan which must be completed within 48 hours to determine if the facility is providing appropriate care and services based on information available at the time of admission.

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

Examples of Severity Level 4 Noncompliance Immediate Jeopardy to Resident Health or Safety include, but are not limited to:

- The facility failed to keep corrosive cleaning supplies out of the reach of ambulatory residents with dementia, resulting in one resident ingesting drain opener and sustaining esophageal damage.*
- The facility failed to provide supervision to a unit which had ambulatory cognitively impaired residents. The facility failed to keep these residents from gaining access to the employee locker room. When the surveyor conducted her tour of the facility, she found a confused resident who was trapped in the employee locker room.*

Examples of Severity Level 3 Noncompliance Actual Harm that is Not Immediate Jeopardy include, but are not limited to:

- The facility failed to apply a smoking apron to a resident while smoking, which was necessary and documented on the care plan. The resident sustained a 2nd degree burn after the cigarette fell onto his/her lap.*
- The facility failed to use a two-person transfer, as determined necessary by the comprehensive, during a transfer from the resident's bed to wheelchair, resulting in the resident falling to the floor, sustaining a laceration requiring sutures.*

Examples of Severity Level 2 Noncompliance No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy include, but are not limited to:

- *The facility failed to remove clutter and building materials from a construction area, immediately adjacent to a walkway used by residents and their families, creating a hazard which poses a risk for more than minimal harm.*
- *The facility failed to reassess the resident and his fall risks, determine root causes of fall, and revise the care plan interventions if indicated, for a resident who fell, sustaining only a bruised forehead.*

Severity Level 1 Noncompliance No Actual Harm with Potential for Minimal Harm

The failure of the facility to provide a safe environment and adequate supervision places residents at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

MEMORANDUM OF DIRECTION

DATE:

TO: All Nursing staff

FROM: Director of Nursing

SUBJECT: Fall Prevention Program

All residents will receive adequate supervision, assistance, and assistive devices to aid in the prevention of falls. Each resident will be evaluated for safety risks including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in the prevention of falls.

All Falls are to be investigated and monitored. The facility will maintain a record that contains a list of all incidents and falls. The recording trends are reported and discussed at Quality Assurance Risk Management Committee Meetings monthly and quarterly. The Risk Manager is responsible for coordinating all investigations. If the Incident/Fall meets the Adverse Incident criteria, the Adverse Reporting procedure will be followed according to Federal and State Laws.

Upon admission, the Admitting Nurse will complete the Accident Risk Evaluation. The evaluation will be completed after each fall, unless the resident experiences two falls within a 24 hour period. The Accident Risk Evaluation is also to be completed in conjunction with the RAI Process.

When a resident experiences a witnessed or unwitnessed fall, as the Nurse responsible for the resident, complete the following in the resident's electronic medical record and follow the following guidelines: the SBER Change in Condition Evaluation, Post – Fall Huddle Report, and the incident report in Risk Management.

The Unit Manager or designee will complete the Accident/Incident Confidential Investigation Report and submit the form to the Risk Manager or designee.

The Risk Manager or designee will complete the Event Completion Checklist for all falls to affirm compliance with the program and evaluate the risk for the need for reporting as required by State and Federal laws.

The Risk Manager or designee will complete the Post Accident Incident Audit Too monthly, or as directed by the Director of Nursing, and submit this form along with a monthly fall report to the Risk Management Quality Assurance Performance Improvement Committee.

I. INVESTIGATIVE GUIDELINES

- A. Check resident for injuries.
 - i. Vital Signs
 - ii. Neuro-checks, for head injuries or un-witnessed fall and resident unable to communicate if he hit his/her head.
 - iii. Visual check for cuts, bruises, abrasions, redness, or deformities.
- B. Secure resident
- C. Call Post-Fall Huddle and complete form
- D. If injury is serious, contact physician or call 911 immediately
- E. Contact NHA
- F. Contact DON
- G. Contact Supervisor, or Unit Manager
- H. Notify physician, family/responsible party of fall
- I. Complete Incident Report in Risk Management
- J. Update the Accident Risk Evaluation Tool
- K. Start Investigative Report
- L. Obtain detailed statements from ANY witnesses. Statements must be signed with the correct date and time for falls with serious injuries.
- M. Document in the Nurses Notes:
 - i. Observed circumstances; resident fell, slid from chair, found on floor, etc.
 - ii. Note if any injuries
 - iii. Physician contacted
 - iv. Resident Representative contacted
 - v. Vital Signs
 - vi. Neuro-checks
 - vii. Any medications taken
 - viii. Time of Toileting (if pertinent)
 - ix. Any other pertinent observations
 - x. Implement any directions given by the Administrator and/or RN on call.
 - xi. Use the Fall Intervention form for possible immediate approaches to use in care of the resident.
- N. Continue to observe resident throughout shift and provide a thorough report for the next oncoming shift (includes Nurses and C.N.A.s)
- O. Each nurse, each shift will observe resident and document for 72 hours in the resident's medical record.

- i. Vital Signs
 - ii. Neuro-checks (for unwitnessed falls)
 - iii. Behavior changes
 - iv. Physical changes
 - v. Neurological changes
- P. If resident has to be sent out of the facility, initiate the Abuse and or Adverse Incident investigation process. Notify the Risk Manager.
- Q. Use the Fall Intervention form for possible immediate approaches to implement status post incident/fall.
- R. Risk Manager or designee will add the investigation information into Risk Management.

II. Quality Assurance/Risk Management Guidelines

- A. Responsibility of Risk Manager/Designee
- Review Incident report for completeness
 - Ensure Accident Risk Evaluation has been updated
 - Complete Investigative Report
 - Review the Accident/Incident in the next morning Stand up meeting for any follow-up and care plan review.
 - Therapy to screen resident that falls as referred and recommend appropriate interventions.
 - Care plan is to be updated with any new interventions.
 - Nursing staff is to document Q shift for 72 hours.
 - Trending and Tracking to be completed at end of month and report given at the QAPI monthly/quarterly meetings.
 - The Abuse and Adverse Reporting Protocol to be initiated when appropriate.
- B. The Interdisciplinary Team (IDT) will meet within the same period of time and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary and revise the care plan if necessary.
- C. Rehabilitation therapy will screen referred resident within 24 hours after a fall, unless the fall occurs on a weekend, then the screen will be done on Monday. They will then obtain an order for the appropriate course of treatment or write a restorative program that will assist in reducing further falls.
- D. When a resident has more than one fall in a 24-72 hour period of time, one screening and recommendation will suffice, unless the IDT deems otherwise.
- E. If the resident sustained an injury requiring care that you cannot provide, or Abuse is suspected or alleged, then initiate the appropriate reporting requirements for State and Federal reporting.

PROCEDURE

SUBJECT: Falling Star Program

DATE:

INTENT:

All residents will receive adequate supervision, assistance, and assistive devices to aid in the prevention of falls. Each resident will be evaluated for safety risks including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in the prevention of falls.

All Falls are to be investigated and monitored. The facility will maintain a record that contains a list of all incidents and falls. The recording trends are reported and discussed at Quality Assurance Risk Management Committee Meetings monthly and quarterly. The Risk Manager is responsible for coordinating all investigations. If the Incident/Fall meets the Adverse Incident criteria, the Adverse Reporting procedure will be followed according to Federal and State Laws.

It is the policy of the facility to report Accidents and Incidents in accordance to State and Federal regulations.

DEFINITIONS:

An "accident" is an unexpected, unintended event that can cause a resident bodily injury.

A "fall" is the unintentional coming to rest on a lower surface, such as a chair, the bed, or the floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).

An "intercepted fall" occurs when a resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person (this is still considered a fall regardless if the resident does not hit the floor).

A "fracture related to a fall" is any documented bone fracture (in a problem list from a medical record, an x-ray report, or by a history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes, or pedestrian versus car accidents, or impact of another person or object against the resident.

Falls are **NOT** a result of an overwhelming external force (e.g., a resident pushes another resident).

PROGRAM STEPS:

I. INVESTIGATIVE GUIDELINES

- A. Check resident for injuries.
 - i. Vital Signs
 - ii. Neuro-checks, for head injuries or un-witnessed fall and resident is unable to communicate if he hit his/her head.
 - iii. Visual check for cuts, bruises, abrasions, redness or deformities.
- B. Secure resident
- C. Call Post-Fall Huddle and complete form
- D. If injury is serious, contact physician or call 911 immediately
- E. Contact NHA
- F. Contact DON
- G. Contact Supervisor, or Unit Manager
- H. Notify physician, family/responsible party of fall
- I. Complete Incident Report in Risk Management
- J. Update the Accident Risk Evaluation Tool
- K. Start Investigative Report
- L. Obtain detailed statements from *ANY* witnesses. Statements must be signed with the correct date and time for falls with serious injuries.
- M. Document in the Nurses Notes:
 - i. Observed circumstances; resident fell, slid from chair, found on floor, etc.
 - ii. Note if any injuries
 - iii. Physician contacted
 - iv. Resident Representative contacted
 - v. Vital Signs
 - vi. Neuro-checks
 - vii. Any medications taken
 - viii. Time of Toileting (if pertinent)
 - ix. Any other pertinent observations
 - x. Implement any directions given by the Administrator and/or RN on call.
 - xi. Use the Fall Intervention form for possible immediate approaches to use in care of the resident.
- N. Continue to observe resident throughout shift and provide a thorough report for the next oncoming shift (includes Nurses and C.N.A.s)
- O. Each nurse, each shift, will observe resident and document for **72** hours in the resident's medical record.
 - i. Vital Signs
 - ii. Neuro-checks (for unwitnessed falls)
 - iii. Behavior changes
 - iv. Physical changes
 - v. Neurological changes

- P. If resident has to be sent out of the facility, initiate the Abuse and or Adverse Incident investigation process. Notify the Risk Manager.
- Q. Use the Fall Intervention form for possible immediate approaches to implement status post incident/fall.
- R. Risk Manager is to add the resident to the Incident/Fall follow up log.

II. Quality Assurance/Risk Management Guidelines

- A. Responsibility of Risk Manager/Designee
 - Review Incident report for completeness
 - Ensure Accident Risk Evaluation has been updated
 - Complete Investigative Report
 - Review the Accident/Incident in the next morning Stand up meeting for any follow-up and care plan review.
 - Therapy to screen resident that falls as referred and recommend appropriate interventions.
 - Care plan is to be updated with any new interventions.
 - Nursing staff is to document Q shift for 72 hours.
 - Trending and Tracking to be completed at end of month and report given at the QAPI monthly/quarterly meetings.
 - The Abuse and Adverse Reporting Protocol to be initiated when appropriate.
- B. The Interdisciplinary Plan of Care (IPOC) team will meet within the same period of time and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary and revise the care plan if necessary.
- C. Rehabilitation therapy will screen referred resident within 24 hours after a fall, unless the fall occurs on a weekend, then the screen will be done on Monday. They will then obtain an order for the appropriate course of treatment or write a restorative program that will assist in reducing further falls.
- D. When a resident has more than one fall in a 24-72 hour period of time, one screening and recommendation will suffice unless the IPOC team deems otherwise.
- E. If the resident sustained an injury requiring care that you cannot provide or Abuse is suspected or alleged, then initiate the appropriate reporting requirements for State and Federal reporting.

III. Fall Reduction Program “Falling Star Program”

- A. Program Goal:

The Falling Star Program is a comprehensive program designed to identify and address residents 'actively at risk' for falls. This is in accordance to assisting residents maintain a safe and comfortable environment while residing in the facility. By creating such a program, our goals will be to reduce the number of falls and or falls with injury on a monthly, quarterly, and annual basis.

B. Staff Involvement:

The Falling Star Program will be a full facility program, including all disciplines, 24 hours a day, seven days a week. The Falling Star Program will be in-serviced to all facility staff on hire, annually, and PRN as dictated by Department Heads and/or the Administrator.

C. Criteria:

The criteria for inclusion in the Program include:

1. Resident has been identified as a fall risk (fall score of 15 or greater) on their admission Accident Risk Evaluation, or on their admission minimum data set (MDS), and/or
2. The resident is on an **anticoagulant**, and/or
3. Has **moderate to severe Osteoporosis**.
4. Resident has a new fall from standing, sitting, lying position.

The criteria for discontinuance of a resident in the Program:

1. Resident is no longer identified as a moderate/high fall risk for 30 or more days,
2. Resident is capable of following safety instructions, and/or remembers to use the call bell. (IDT) discussion.
3. Resident has not sustained a fall in the last 60 days, and/or
4. Resident has had no injury from a fall in the last 90 days,
5. The Inter Disciplinary Team decision.

D. The Falling Star Identification:

1. Residents who are included in the Falling Star Program will be identified with a Star. The star will be placed outside resident's room (with the resident's bed number written neatly off center for identification when in semi-private rooms), wheelchairs, walkers, and/or canes.

E. Program description will include:

1. Monitor shower rooms for non-slip surfaces,

2. Monitor all assistive equipment (e.g., wheelchairs, walkers, etc.) for broken or loose parts,
3. Keep floors in the hallways and rooms dry and clutter-free,
4. Identify all residents at risk for falls,
5. Monitor medications for side-effects that can cause dizziness,
6. Monitor handrails and other objects for sharp edges, broken parts, etc.,
7. Remove items that are out of place in rooms and resident common areas to avoid tripping (e.g., trash cans, linen carts, etc.),
8. Check residents who are using alarms (bed, chair),
9. Monitor lighting for burnt out light bulbs, and
10. STOP, LOOK, and LISTEN.

IV. FORMS

- **Accident/Incident Report**
- **Post Fall Huddle Report**
- **SNF Confidential Facility Investigation Report**
- **Fall Review and Interventions – Possible Immediate Approaches**
- **Event Completion Checklist**
- **Accident/Incident Surveillance Tracking Log**
- **Accident Risk Evaluation**

Point of Emphasis:

Each time an employee (any department) walks past a resident room or resident identified with a STAR the employee will **STOP, LOOK, and LISTEN** to assure that the resident is safe and not in an unsafe situation.

Falling Star Program Intervention List

- Ambulation Program
- Bowel and Bladder Evaluation/Program(use with Falls going to the Bathroom)
- Increase Activities in the Evening after dinner (e.g. folding towels/clothes)
- Dycem to chair
- Non-Slip strips on floor
- Non-slip shoes
- Non-slip socks
- 1/4 or 1/2 Rails for support
- Medication Regime Review MRR Pharmacy Request
- UA/CS after medical/medication issue ruled out (please document what was done prior to lab order)
- Q 15 minute check (document on form)
- Keep in view of staff when OOB
- Psychological Evaluation
- Orthostatic Vital Signs
- Low bed with mats
- Stop signs
- Anti-tippers for the wheel chair
- Snack Time
- Written instruction to resident (use call light for assist)
- Afternoon nap
- Pain management Program
- Encourage family to visit
- Soothing Music
- Quiet Environment
- Take resident outside
- One on One Supervision (e.g. PRN given for agitation and attempting to self- transfer. 1:1 for 30 minutes to ensure meds effective)
- Exercise Program
- Raised toilet seat
- Hipsters
- Schedule individual activity
- Scoop Mattress
- Bible to hold
- Family Photo Album to hold
- Lavender Lotion hand massage
- Pet Therapy
- Change nap time
- Change bed time
- Education to ask for assistance
- Call bell within reach
- Self- Locking Brakes
- Room free from clutter
- Evaluate Preferences
- Red W/C locks as a visual reminder to lock brakes
- Therapy Referral with all falls except repeated falls within 24-72 hours unless otherwise deemed necessary

POLICY/PROCEDURE

SUBJECT: Reporting Accidents and Incidents

DATE:

INTENT:

It is the policy of the facility to report Accidents and Incidents in accordance with State and Federal regulations.

PROCEDURE:

1. The Incident and Accident Reporting System will include a comprehensive process to allow for:
 - a. Collection of the incident and accident occurrence
 - b. Investigation of incidents and accidents
 - c. Evaluation of injuries of unknown source (IUS)
 - d. Tracking and Trending of incidents and accidents
2. The Incident Report will be completed by the Nurse assigned to the resident at the time of the event, within the Risk Management section of the electronic medical record, and begin the investigation.
3. The Investigation will be completed by the Director of Nursing(DON) or designee within 72 hours from the event.
4. The DON or designee will track incidents and accidents within the facility Electronic Medical Record's Risk Management system.
5. Monthly during the facility Risk Management Quality Assurance Meeting, the results of the Incident and Accident Tracking System will be evaluated.
6. The facility will ensure that:
 - a. The resident environment remains as free from accident hazards as is possible; and
 - b. Each resident receives adequate supervision and assistance devices to prevent accidents.

- c. Every attempt is made to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.
 - I. Assess the resident for risk of entrapment from bed rails prior to installation.
 - II. Review the risks and benefits of bed rails with the resident or resident representative, and obtain informed consent prior to installation.
 - III. Ensure that the bed's dimensions are appropriate for the resident's size and weight.
7. The facility will provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
 - a. Identifying hazard(s) and risk(s);
 - b. Evaluating and analyzing hazard(s) and risk(s);
 - c. Implementing interventions to reduce hazard(s) and risk(s); and
 - d. Monitoring for effectiveness and modifying interventions when necessary.
8. The facility will identify each resident at risk for accidents and/or falls, and adequately plan care and implement procedures to prevent accidents.
9. The facility will ensure each resident receives adequate supervision and assistive devices to prevent accidents.
10. The facility will develop and implement an accident and incident reporting system that will report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.
11. The reporting system will consist of:
 - a. Report all alleged violations and all substantiated incidents to the state agency, and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation;
 - b. Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and
 - c. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.
12. The facility will:
 - a. Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Social Security Act. The

policies and procedures must include but are not limited to the following elements:

- i. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will:
 - Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours, if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
 - Have evidence that all alleged violations are thoroughly investigated.
 - Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
 - Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

13. The facility will develop appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk management and risk prevention for all non-physician personnel, as follows:
 - a. Risk Management Training at orientation
 - b. Risk Management Training - 1 Hour Annually

14. The facility will conduct an internal risk management and quality assurance program to include the use of incident reports to be filed with the risk manager and facility administrator. The risk manager shall have free access to all resident records of the licensed facility. The incident reports are part of the work papers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court.

A person filing an incident report is not subject to civil suit by virtue of such incident report. As part of the each internal risk management and quality assurance program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

15. The facility will ,for purposes of reporting to the agency, use the term "adverse incident" which means: An event over which facility personnel could exercise control and which is associated in whole or in part with the facility's intervention, rather than the condition for which such intervention occurred, and which results in one of the following:
 - a. Death;
 - b. Brain or spinal damage;
 - c. Permanent disfigurement;
 - d. Fracture or dislocation of bones or joints;
 - e. A limitation of neurological, physical, or sensory function;
 - f. Any condition that required medical attention to which the resident has not given his or her informed consent, including
 - g. failure to honor advanced directives; or
 - h. Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident; or
 - i. An event reported to law enforcement or its personnel for investigation; or
 - j. Resident elopement, if the elopement places the resident at risk of harm or injury.

16. The facility will ensure the risk manager:
 - a. Investigates every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact when the allegation is that the sexual misconduct occurred at the facility or at the grounds of the facility;
 - b. Reports every allegation of sexual misconduct to the administrator of the licensed facility; and
 - c. Notifies the resident representative or guardian of the victim that an allegation of sexual misconduct has been made and that an investigation is being conducted.

17. The facility will complete the investigation and submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence. If after a complete investigation, the risk manager determines that the incident was not an adverse incident the facility shall include this information in the report.

POLICY/PROCEDURE

SUBJECT: Safety Awareness

DATE:

INTENT:

It is the policy of the facility to provide Safety Awareness in accordance to State and Federal regulations.

PROCEDURE:

1. The facility will be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.
2. The facility will maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.
3. The facility will provide one or more rooms designated for resident dining and activities.
4. The facility will ensure that the designated areas are well lighted, well ventilated, adequately furnished, and have sufficient space to accommodate all activities.
5. The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.
6. The facility will have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.
7. The facility will maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.
8. The facility will provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible.
9. The facility will provide:
 - a. housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
 - b. clean bed and bath linens that are in good condition;
 - c. private closet space for each resident;
 - d. furniture, such as a bed-side cabinet, drawer space;
 - e. adequate and comfortable lighting levels in all areas;
 - f. comfortable and safe temperature levels; and
 - g. the maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the resident will be tuned to stations of the resident's choice.

10. The facility will equip corridors with firmly secured handrails on each side.
11. The facility will maintain an effective pest control program so that the facility is free of pests and rodents.
12. The facility will maintain adequate lighting levels in all areas suitable to tasks the resident chooses to perform or the facility staff must perform. Comfortable lighting will minimize glare and provide maximum resident control, where feasible, to maintain or enhance independent functioning.
13. The facility will maintain comfortable and safe temperature levels between 71-81 degrees F (Fahrenheit).
14. The facility will maintain comfortable sound levels that do not interfere with resident's hearing and enhance privacy and social interaction as desired.
15. The facility will maintain resident rooms designed and equipped for adequate nursing care, comfort, and privacy of the residents. Resident rooms will:
 - a. Accommodate no more than four residents unless a variance has been applied for and approved, for facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents.
 - b. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.
 - c. Have direct access to an exit corridor.
 - d. Be designed and equipped to assure full visual privacy for each resident.
 - e. Have at least one window to the outside and have a floor at or above grade level.
16. The facility will provide each resident with:
 - a. A separate bed of proper size and height for the safety and convenience of the resident.
 - b. A clean, comfortable mattress.
 - c. Bedding appropriate to the weather and climate.
 - d. Functional furniture appropriate to the resident needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.
17. The facility will ensure that each resident room must be equipped with or located near toilet and bathing facilities. For facilities that receive approval of construction from State and local authorities or are newly certified after November 28, 2016, each residential room must have its own bathroom equipped with at least a commode and sink.

18. The facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member, or to a centralized staff work area, from toilet and bathing facilities.
19. The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.
20. The facility will establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.
21. The facility will establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

ACCIDENT RISK EVALUATION

(This may also be used to meet the intent of CAA 11)

Resident Name: _____					Room: _____			
CONDITIONS	0	1	2	3	SCORE			
Note a fall or any falls any time in the last month prior to admission/entry or reentry?	<input type="checkbox"/> NO: if Resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the Resident's entry date. If NO, score 0. <input type="checkbox"/> YES: if Resident or family report or transfer records or medical records document a fall in the month preceding the Resident's entry date. If YES, score 3. UNABLE TO DETERMINE: if the Resident is unable to provide the information or if the Resident and family are not available or do not have information and medical record information is inadequate to determine whether a fall occurred. If UNABLE TO DETERMINE, score 0.				DATE:	DATE:	DATE:	DATE:
Note a fall or any falls since admission/entry or reentry or prior assessment, whichever is more recent?	No Falls	One Fall	Two Falls	Three or more Falls				
Note a fall or any falls with injury?	No Falls	Fall with no injury	Fall with minor injury - skin tears, abrasions, laceration, superficial bruises, hematomas, or sprains	Fall with major injury - fractures, dislocations, closed head injuries, subdural hematoma				
COGNITIVE STATUS:	NO LIMITATIONS Alert, orientated x4 (person, place, time & situation) decisions consistent and reasonable	SLIGHTLY IMPAIRED Occasional confusion; some difficulty in new situations only	MODERATELY IMPAIRED Frequently confused and disoriented; decisions poor; requires cues and supervision	SEVERELY IMPAIRED Continual confusion; decisions never or rarely made/also includes comatose Resident				
PHYSICAL PERFORMANCE LIMITATIONS: Balance, gait, strength, muscle endurance	<input type="checkbox"/> Difficulty maintaining sitting balance <input type="checkbox"/> Need to rock body or push off on arms of chair when standing up from chair <input type="checkbox"/> Difficulty maintaining standing position <input type="checkbox"/> Impaired balance during transitions <input type="checkbox"/> Gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait <input type="checkbox"/> One leg appears shorter than the other <input type="checkbox"/> Musculoskeletal problem, such as kyphosis, weak hip flexors from extended bed rest, or shortening of a leg (1 or more equals score of 3)							
MEDICATIONS - Number of the following medications: Antipsychotics, Antianxiety agents, Antidepressants, Hypnotics, Cardiovascular, Diuretics, Narcotics, or Neuroleptics, Anticoagulants	None	One	Two	Three or more				

ACCIDENT RISK EVALUATION

(This may also be used to meet the intent of CAA 11)

Resident Name: _____					Room: _____			
CONDITIONS	0	1	2	3	SCORE			
INTERNAL RISK FACTORS From diagnosis list and clinical indicators.	<input type="checkbox"/> Circulatory/Heart <input type="checkbox"/> Neuromuscular / Functional <input type="checkbox"/> Orthopedic			<input type="checkbox"/> Psychiatric or Cognitive <input type="checkbox"/> Pulmonary <input type="checkbox"/> Pain (2 or more equals score of 3)	DATE:	DATE:	DATE:	DATE:
LABORATORY TESTS Hypo or Hyperglycemia, Electrolyte imbalance, Dehydration, Hemoglobin and Hematocrit, INR	One or more equals a 3.							
TISSUE TRAUMA	Is there evidence of skin tears and or bruising to upper or lower extremities? <input type="checkbox"/> Yes or <input type="checkbox"/> No Are these areas of tissue trauma related to a previous fall or transfer? <input type="checkbox"/> Yes or <input type="checkbox"/> No or <input type="checkbox"/> Unable to determine If yes, implement the following interventions in the Residents plan of care, as indicated: <input type="checkbox"/> Treatment as ordered <input type="checkbox"/> Moisturizer to skin during morning and evening ADL care, <input type="checkbox"/> Tissue Protectors to <input type="checkbox"/> upper extremities / <input type="checkbox"/> lower extremities <input type="checkbox"/> Transfer assistance of 2							
SIDE RAIL USE	Is the resident able to follow instructions? <input type="checkbox"/> Yes or <input type="checkbox"/> No Does the resident's mood and behavior vary over the course of the day; is there a history of agitation? <input type="checkbox"/> Yes or <input type="checkbox"/> No Are there contractures to the hands, wrists, or elbows? <input type="checkbox"/> Yes or <input type="checkbox"/> No Is there a loss of mobility, reduced movement, weakness or paralysis to the dominant upper extremity? <input type="checkbox"/> Yes or <input type="checkbox"/> No *Does the resident require a specialty mattress that indicates the use of side rails? <input type="checkbox"/> Yes or <input type="checkbox"/> No *Is the resident/resident representative requesting use of side rail(s)? <input type="checkbox"/> Yes or <input type="checkbox"/> No NOTE: If yes to either of the last two questions the Side Rail Evaluation must be completed							
SMOKING EVALUATION	Does the resident smoke? <input type="checkbox"/> Yes or <input type="checkbox"/> No If Yes, continue. Is the resident able to safely light the cigarette? <input type="checkbox"/> Yes or <input type="checkbox"/> No Is the resident able to safely extinguish the cigarette? <input type="checkbox"/> Yes or <input type="checkbox"/> No Are there visible upper extremity tremors? <input type="checkbox"/> Yes or <input type="checkbox"/> No Are there contractures to the hands, wrists, or elbows? <input type="checkbox"/> Yes or <input type="checkbox"/> No Is there a loss of mobility, reduced movement, weakness or paralysis to the dominant upper extremity? <input type="checkbox"/> Yes or <input type="checkbox"/> No NOTE: When two or more are checked (YES), use smoking apron until Occupational Therapy screens for and recommendations are made regarding safe smoking. NOTE: When the resident smokes, review the facility smoking policy and explain all residents are monitored during times of smoking and smoking items are maintained at the nurse's station.							

ACCIDENT RISK EVALUATION

(This may also be used to meet the intent of CAA 11)

Resident Name: _____					Room: _____				
CONDITIONS	0	1	2	3	SCORE				
EXIT SEEKING EVALUATION	<p>A. Elopement Risk Assessment</p> <ol style="list-style-type: none"> 1. Is this resident ambulatory? <input type="checkbox"/> Yes or <input type="checkbox"/> No <ol style="list-style-type: none"> a. Is the resident able to walk alone without assistive devices? <input type="checkbox"/> Yes or <input type="checkbox"/> No b. Is the resident able to walk with walker or another assistive device or use wheelchair, independently? <input type="checkbox"/> Yes or <input type="checkbox"/> No c. Does the resident require assistance of another to ambulate or be mobile via wheelchair? <input type="checkbox"/> Yes or <input type="checkbox"/> No 2. Is the resident resistant to being at facility? <input type="checkbox"/> Yes or <input type="checkbox"/> No 3. Does the resident have a history of wandering or exit seeking behavior? <input type="checkbox"/> Yes or <input type="checkbox"/> No 4. Is the resident currently taking any medication which may cause confusion or disorientation, such as narcotics or psychoactives? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Are there any indications or diagnosis of cognitive impairment or dementia? <input type="checkbox"/> Yes or <input type="checkbox"/> No 6. Can the resident physically leave the facility unassisted? <input type="checkbox"/> Yes or <input type="checkbox"/> No (This question is answered based on the resident's physical ability, not safety) <p>B. Actions/Interventions</p> <ol style="list-style-type: none"> 1. Based on the above evaluation and answering yes to questions 2, 3, & 6, it has been determined that the resident is at risk for elopement and a 90-day signaling device (WanderGuard) placement is recommended? <input type="checkbox"/> Yes or <input type="checkbox"/> No 2. Device has been determined: a. <input type="checkbox"/> to be placed b. <input type="checkbox"/> not to be placed <ol style="list-style-type: none"> a. Due to the following reason(s): [Document rationale for proceeding to a signaling device or not] _____ 3. Was a signaling device [WanderGuard] placed? <input type="checkbox"/> Yes or <input type="checkbox"/> No <ol style="list-style-type: none"> a. If yes, what limb was device placed? _____ b. If yes, was the care plan updated? <input type="checkbox"/> Yes or <input type="checkbox"/> No c. Family Notification was completed on: _____ 				DATE:	DATE:	DATE:	DATE:	
TOTAL	Enter Total of all columns:								
0 - 9 = Low Risk for falls ; 10 - 15 = Moderate Risk for falls ; 16 and greater = High Risk for falls					Date:				
					Initial:				
INITIAL(S)	DATE(S)	SIGNATURE(S) OF ABOVE EVALUATION			INITIAL(S)	DATE(S)	SIGNATURE(S) OF ABOVE EVALUATION		
_____	_____	_____			_____	_____	_____		
_____	_____	_____			_____	_____	_____		
_____	_____	_____			_____	_____	_____		
_____	_____	_____			_____	_____	_____		

ACCIDENT RISK EVALUATION

(This may also be used to meet the intent of CAA 11)

Resident Name: _____ Room: _____

Input from Resident and/or family/representative regarding risk for falls: _____

Analysis and Findings	Care Plan	Care Plan Considerations
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Review indicators and supporting documentation and draw conclusions.
 Document: Description of problem, need or concern, Causes and contributing factors, and Risk factors related to care area.

Yes No

Document reasons care plan will/will not be developed.

Note if a referral to another discipline is warranted, if so, to whom and why: _____

Information regarding this CAA has been transferred to the CAA summary sheet? Yes No By Signature: _____ Date: _____

Signatures & Dates of Completion / Review

ACCIDENT AND INCIDENT OCCURRENCE REPORT

General Information:

Name: _____ Date: _____ Time: _____
If Resident, Room #: _____ Location of Occurrence: _____
Address/Phone if not a Resident: _____

Reason at Facility:

Resident Visitor

Occurrence:

Please Select # 1, 2, or 3

1. **No Injury** (no evidence of injury noted after evaluation, no pain complaint, & no change in behavior)
2. **Injury: except major** skin tear abrasions lacerations superficial bruises
 hematomas sprains any fall related injury with c/o pain
3. **Injury: major** fractures dislocations closed head injury
 altered level of consciousness subdural hematoma

VS: T _____ P _____ R _____ BP _____

Alleged Fall Witnessed Fall Found on Floor

Describe any Details: _____

Details by: _____ LPN or RN

Notifications:

N/A, Resident is own responsible party and stated to this Nurse that they preferred no one to be called.

Who was notified? _____ Relationship: _____ Date/Time: _____

Name of Physician: _____ Date notified: _____ Time notified: _____

Completed & Initial Review by:

Nurse Completing Report LPN/RN Title Date Time

Supervisor LPN/RN Title Date Time

Reviewed By:

Director of Nursing Date Medical Director Date

Administrator Date Risk Manager Date

Post – Fall Huddle Report

Resident Name: _____ **Med. Rec. #:** _____ **Room #:** _____

KNOWN CAUSE <input type="checkbox"/> From Bed <input type="checkbox"/> Fainted <input type="checkbox"/> From Chair or Wheel Chair <input type="checkbox"/> From Equipment/Table <input type="checkbox"/> From Commode/Toilet <input type="checkbox"/> While Ambulating <input type="checkbox"/> Other: _____	TYPE OF LIGHT IN USE <input type="checkbox"/> Room Light <input type="checkbox"/> Over Bed Light <input type="checkbox"/> Night Light <input type="checkbox"/> Night Light <input type="checkbox"/> None <input type="checkbox"/> Other: _____ LIGHTING ADEQUATE? <input type="checkbox"/> Yes <input type="checkbox"/> No	USING ASSISTIVE DEVICES DURING FALL? <input type="checkbox"/> Side Rail <input type="checkbox"/> Mechanical Lift <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Walker <input type="checkbox"/> Hand Rails <input type="checkbox"/> Grab Rails <input type="checkbox"/> Gait Belt <input type="checkbox"/> Wedge Cushion <input type="checkbox"/> Dycem <input type="checkbox"/> Anti-Rollback <input type="checkbox"/> Anti-Tippers <input type="checkbox"/> Cane LEG REST? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---

IDENTIFICATION MEANS <input type="checkbox"/> Witness By: <input type="checkbox"/> Staff <input type="checkbox"/> Resident <input type="checkbox"/> Visitor <input type="checkbox"/> Initials of above: _____	SURFACE <input type="checkbox"/> Tile <input type="checkbox"/> Linoleum <input type="checkbox"/> Carpet <input type="checkbox"/> Area Mat <input type="checkbox"/> Other: _____ Wet? <input type="checkbox"/> Yes <input type="checkbox"/> No	EQUIPMENT ABOVE CHECKED POST FALL? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If Yes, which items checked: _____ Above in working Order? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Action: _____
---	--	--

UNKNOWN CAUSE <input type="checkbox"/> Found on Floor <input type="checkbox"/> Found but not on Floor <input type="checkbox"/> Location: _____	PATHWAY <input type="checkbox"/> Clear <input type="checkbox"/> Cluttered	TOILETING / PERI CARE <input type="checkbox"/> Attempting to go to the toilet without staff assistance <input type="checkbox"/> Had soiled garments on that may have contributed to fall
--	--	---

TYPE OF FALL <input type="checkbox"/> Slip <input type="checkbox"/> Legs gave away <input type="checkbox"/> Trip <input type="checkbox"/> Unknown <input type="checkbox"/> Undue Force (i.e. pushed) <input type="checkbox"/> Assisted to floor by staff <input type="checkbox"/> Other: _____	RESIDENT WEARS EYE GLASSES <input type="checkbox"/> No <input type="checkbox"/> Reading <input type="checkbox"/> Seeing <input type="checkbox"/> Bi-Focal GLASSES WORN DURING FALL? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	HAVING BM DURING OR PRIOR TO FALL? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, last toileted or changed _____ Hrs. ago <input type="checkbox"/> Possible Vasovagal response - further evaluation needed Last Bowel Movement occurred on: _____
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FALL DIRECTION <input type="checkbox"/> Drop <input type="checkbox"/> Sideways <input type="checkbox"/> Forwards <input type="checkbox"/> Backwards <input type="checkbox"/> Unknown	FOOTWEAR <input type="checkbox"/> None (Bare Foot) <input type="checkbox"/> Socks <input type="checkbox"/> Tennis Shoes <input type="checkbox"/> Casual Shoes <input type="checkbox"/> Thongs <input type="checkbox"/> Sandals <input type="checkbox"/> Slippers <input type="checkbox"/> Non-Skid Socks <input type="checkbox"/> Other: _____	POST PRANDIAL HYPOTENSION Meal consumed within one hour prior to fall? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possible Postprandial hypotension - further evaluation needed
--	--	--

CALL BELL IN REACH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Location: _____	SHOELACES <input type="checkbox"/> N/A <input type="checkbox"/> Tied <input type="checkbox"/> Untied Sole of shoe with thread? <input type="checkbox"/> Yes <input type="checkbox"/> No	MEDICATIONS <input type="checkbox"/> New Medication in the last 7 days <input type="checkbox"/> Cardiovascular / Antihypertensive / Diuretic Medication <input type="checkbox"/> Psychoactive Medications
--	--	---

CALL BELL WORKING <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> In use at time of fall <input type="checkbox"/> Not in use at time of fall	CLOTHING <input type="checkbox"/> Did not impact fall <input type="checkbox"/> Did impact fall	MOBILITY <input type="checkbox"/> Ambulatory <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Independent <input type="checkbox"/> Mechanical Lift <input type="checkbox"/> Assist x 1 <input type="checkbox"/> Assist x 2
---	---	--

ACUTE ILLNESS
 Has or may have an acute illness which contributed to fall: Yes No
 If Yes, s/s: _____

WHAT WAS RESIDENT'S MENTAL STATUS BEFORE FALL? (Check all that apply)
 Alert and Oriented Confused Combative Active Aware Crying Lethargic Sleeping
 Anxious Disoriented to Person, Place or Time
 Mental status **after** fall? _____ BIMS Score: _____

ACTIVITY/BEHAVIORS CONTRIBUTING TO FALL: _____

Post – Fall Huddle Report

WHAT DID RESIDENT SAY HAPPENED? _____

INVESTIGATION FINDINGS: _____

HUDDLE RECOMMENDATIONS: _____

EVALUATION FOR HIP FRACTURE

- Neither foot is rotated outward more than 45 degrees
- Left Right, foot is rotated outward more than 45 degrees
- Neither leg is longer than the other
- Left Right, leg is longer than the other
- Neither leg has swelling or bruising in upper thigh area
- Left Right, leg has swelling or bruising in upper thigh area

ROM

- C/O Pain with ROM
- ROM Limitations
- ROM Not Limited

PALPATE SCALP/HEAD FOR ABNORMALITIES

- No Abnormalities
- Abnormality noted

NEUROLOGICAL CHECKS

- Initiated N/A
- See Neur. Flow Sheet

DIABETIC RESIDENTS

- N/A BS is: _____

TYPE OF INJURY: (Check all that apply)

- None Bruise Hematoma Contusion Swelling Abrasion Laceration
- Complaint of Pain FX/Dislocation Skin Tear

PAIN LEVEL NOTED: Scale Used: Verbal or Behavioral (Check all that apply)

- | | | | | | | | | |
|------------------------------------|---------------------------------|-------------------------------------|------------------------------------|---------------------------------|-------------------------------------|-------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Level 0 | <input type="checkbox"/> Verbal | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Level 3-4 | <input type="checkbox"/> Verbal | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Level 7-8 | <input type="checkbox"/> Verbal | <input type="checkbox"/> Behavioral |
| <input type="checkbox"/> Level 1-2 | <input type="checkbox"/> Verbal | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Level 5-6 | <input type="checkbox"/> Verbal | <input type="checkbox"/> Behavioral | <input type="checkbox"/> Level 9-10 | <input type="checkbox"/> Verbal | <input type="checkbox"/> Behavioral |

QUALITY OF PAIN

- Radiating Burning Dull Throbbing Aching Shooting Other: _____

FALL RISK SCREEN:

Completed Score is: _____ Previous Fall Risk Screen Score was: _____

CARE PLAN UPDATED? Yes No, If Yes, List intervention added to decrease risk of another fall:

SIGNATURES

Completed by: _____ Signature: _____ Date/Time: _____

Signature of Supervisor: _____ Date: _____

HUDDLE TEAM MEMBERS

Signature: _____ Date: _____

Nurse Manager Review by Signature: _____ Date: _____

ACCIDENT/INCIDENT CONFIDENTIAL INVESTIGATION REPORT

Resident Name: _____ Date Completed: _____

List Accident/Incident or Allegation: _____

Date of Accident/Incident: ___ / ___ / _____

Accident/Incident Summary: (Who, What, Where, When, and Why?) _____

Injury Description: _____

List any Known Witnesses: _____

Were Statements Taken? Yes No If Yes, please attach

Summarize Resident Considerations (e.g., MDS, CAAs, CPs) _____

Is the resident a credible witness? Yes No Give response rationale:

Is the Resident the alleged Victim, or the alleged Perpetrator?

List Protection Actions (to alleged victim and or alleged perpetrator) _____

ACCIDENT/INCIDENT CONFIDENTIAL INVESTIGATION REPORT

Was any Nursing Agency or others involved? Yes No If Yes, please explain:

List any medications that could impact event:

(e.g., cause or worsen confusion, result in unsteady gait, etc.) _____

Additional Pertinent Clinical Findings: (If attached Check here) _____

Accident/Incident/Allegation Reported to:

State 1-800-227-7308

Immediate Suspicious Crime Report

Federal ANEM Report

State Adverse Incident Reporting

Law Enforcement

Physician

Family/Guardian

Other: _____

Action Plan:

Was an Action Plan Created Related to Accident/Incident or Allegation?

Yes No If No, Explain your response: _____

Findings Summary:

Upon conclusion of the investigation, the facility has determined that the event is being considered for possible adverse reporting process. Yes No

Signatures:

Nurse who completed Report

Director of Nursing Services

Administrator

Risk Manager

EVENT COMPLETION CHECKLIST

FALL/FOUND ON FLOOR/LOWERED TO FLOOR

Resident Name: _____ Date: _____

Number	Check	Duties	Initials
1		Complete a Significant Change SBER.	
2		Notification of the physician and the responsible party.	
3		Document in the Accident Risk Evaluation the new intervention put into place to prevent the incident from occurring on your shift again. Example: 1:1, low bed, alarms. Document any treatment orders obtained from physician.	
4		Complete the Accident Risk Evaluation.	
5		Complete Post Fall Report.	
6		CNA to complete the Fall Questionnaire	
7		Interview any family/visitor/resident that may have knowledge of the incident	
8		Neuro checks initiated including nursing order	
9		Resident name and event placed on 24-hour report sheet	
10		Notify oncoming shift of event to include follow- up needed	
11		Care Plan Updated with new intervention.	
12		Complete request for medication review and fax to the pharmacy.	
13		Notify the Risk Manager and Administrator, of ALL FALLS AND OR ANY OTHER SIGNIFICANT INJURY	
14			
15			
16			

THE NURSING SUPERVISOR IS RESPONSIBLE FOR ENSURE THAT THE PACKET IS COMPLETED IN ITS ENTIRETY PRIOR TO PLACING IN THE UNIT MANAGERS BOX.

Nurse Completing Check list _____ Date: _____

Supervisor Checking Completion: _____ Date: _____

****This is an internal Quality Assurance document and not a part of the clinical record****

Post A/I Audit Tool

INVESTIGATION	YES / NO	COMMENTS
Post Incident Investigation Completed	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Updated Fall Risk Screening Post Event	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last Full MDS Date	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Review of Section J of MDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Review of CAA 11	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Care Plan Updated Timely / Accurately	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Therapy Screen completed	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Star on door	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursing Documentation Supports the Event	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursing Documentation Supports MD/RP Notification	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Adaptive Equipment in place and being utilized correctly	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Resident Initials: _____ Date of Event: _____ Reviewed By: _____

ACCIDENT AND INCIDENT MANAGEMENT & FALL PREVENTION PROGRAM

Objectives

- Fall statistics
- Definitions of Fall and Fall related injury
- Review Federal Regulation Accidents and Supervision
- Federal Abuse Prohibition Review
- Review MDS Section J Coding
- Prevention & Clinical Management
- Root Cause Analysis
- Care Planning

Help!

I've Fallen and I Can't Get Up!

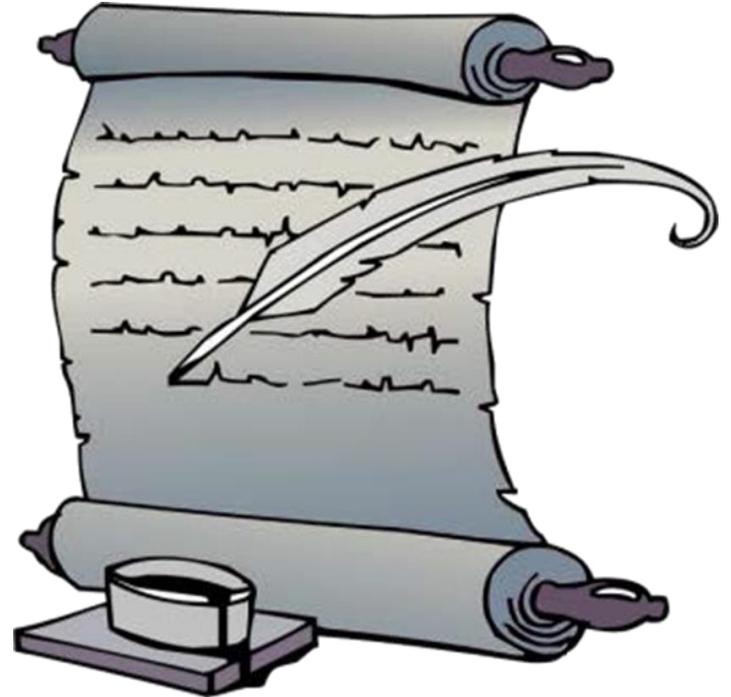


Did you know?

Falls are Leading cause of
Morbidity & Mortality in
Elders?

TRUE

FALSE



Leading Cause of MM

Falls is the leading cause of morbidity and mortality of Seniors not just those in skilled nursing facilities (SNFs) but also in other settings per the Centers of Medicare Medicaid Services (CMS).

*In chapter 4 of your Resident Assessment Instrument manual.

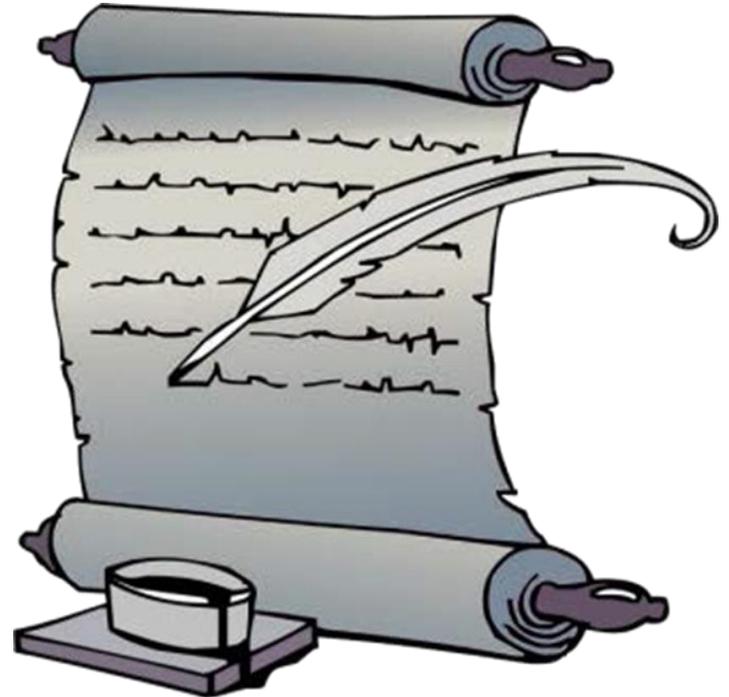
Did you know?

Falls are Leading cause of
Morbidity & Mortality in
Elders?

TRUE



FALSE



Source RAI Manual

Statistics Related to Falls

- Approximately 50% of resident in LTC facilities fall at least once a year and up to 40% fall more than once
- Falls are recorded as a contributing factor in 40% of admissions to LTC facilities

Statistics Related to Falls

- The incidents of falls can double after elderly residents are relocated to a new environment; then they usually return to baseline after 3 months
- Residents 85 and older account for 20% of fall-related deaths in LTC settings

More on Fall Related Statistics

- Approximately 10% of falls result in serious injury
- Approximately half of all fallers who fracture their hips are never functional walkers again and 20% will die within six months of incident

Research (University of Nebraska Omaha)

Results of Post-Fall Huddle completed in 2015 - 17 rural hospitals participated.

With the following results:

- Interdisciplinary team works best
- Falls with injuries decreased by as much as 20 percent
- The severity of the fall reduced by 30 percent

Causations Identified

There were 3 categories listed as causation factors;

- Task directions
- Personal Judgement
- Coordination of staff members

The results:

- Judgement errors were consistently the most at fault
- With the huddle added, task related errors decreased

CMS 2013 REPORT

2.3 million nonfatal fall injuries occur each year among older adults.

600,000 of those result in hospitalization

Conclusion:

- Spending '10' minutes discussing where the errors occurred between staff and departments can save lives, time, and money

Definition of a Fall

Definition of a Fall

The unintentional coming to rest on a lower surface, such as a chair, the bed or the floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).

Intercepted Fall

This occurs when a resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person (this is still considered a fall regardless if the resident does not hit the floor).

Definition of a Fall

The fall may be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or the ground.

Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital, or in a nursing home.

Not Considered a Fall

Falls are **NOT** a result of an overwhelming external force (e.g., a resident pushes another resident).

Definition Fracture r/t Fall

Fracture related to a fall:

Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by a history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes, or pedestrian versus car accidents, or impact of another person or object against the resident.

Accident Hazards Requirements

Accident Hazards

Regulatory Definition

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.

Accident Hazards

Regulatory Definition

Bed Rails – The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

1. Assess the resident for risk of entrapment from bed rails prior to installation.
2. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.
3. Ensure that the bed's dimensions are appropriate for the resident's size and weight.

Interpretive Guideline

INTENT:

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.

Interpretive Guideline

This also includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.

Recognizing Choice v. Safety

There is a balance that CMS encourages all of us to evaluate between the resident choice and the resident safety.

What examples can you think of?

Minimum Data Set Fall Coding

Minimum Data Set Fall Coding

The minimum data set (MDS) is a standardized instrument used to assess nursing home residents. The MDS is a collection of basic physical (e.g., medical conditions, mood, preferences, goal, and interests) information about residents.

Section J 1700 Coding

J1700. Fall History on Admission/Entry or Reentry Complete only if A0310A = 01 or A0310E = 1	
Enter Code <input type="checkbox"/>	A. Did the resident have a fall any time in the last month prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	B. Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	C. Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine

Section J 1800 Coding

Fall History Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code

Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent?

0. No → Skip to K0100, Swallowing Disorder
1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

Section J 1900 Coding

J1900 Number of falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS), whichever is more recent

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent	
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	<input type="checkbox"/> B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/> C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section J 1900 Definitions

Injury Related to a Fall

Any documented injury that occurred as a result of or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

Injury (Except Major)

Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

Section J 1900 Definitions

Major Injury

Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Care Area Assessments 11

Care Area Assessments 11

The goal of care area assessment (CAA) 11 is for the facility to glean from the assessment should be used to help identify and address the underlying cause(s) of the resident fall(s), as well as to identify any related possible causes, and contributing and/or risk factors.

More on CAA 11

When CAA 11 is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing CAAs.

CAAs use a standard clinical risk approach

Strategies for Prevention

Strategies for Prevention

Tracking and Trending:

- Are there a number of accidents or injuries of a specific type or on any specific shift?

Smoking Programs:

- Are residents who smoke properly evaluated?
- Are resident who smoke supervised and monitored?
- What kind of program is in place?

Strategies for Prevention

Fall Follow-up:

- Is the resident assessed for being at risk for falls?
- What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk?
- How did the facility fir, and monitor, the use of that resident's assistive devices?
- How were drugs that may cause postural hypotension, dizziness, or visual changes monitored?

Identifying Risk Factors

Classified as:

- Intrinsic factors – factors that originate with the resident: changes with age(vision, gait, hearing), diseases (chronic and acute), and medication
- Extrinsic factors – factors that are outside the resident: physical environment, assistive devices, and footwear

Intrinsic Factors

Age related changes

- Vision
- Balance and gait
- Psychological
- Change in Mental status
- Medical Conditions
- Multiple Medications

Age Related Changes – Vision

- Decline in visual acuity
- Decrease in color sensitivity
- Decreased depth perception
- Greater sensitivity to glare
- Difficulty in detecting changes in shapes
- Decreased acuity in low lighting
- Decline in light sensitivity

Age Related Changes – Balance

- Decreased sense of body position and movement
- Slower steadying reflexes
- Decreased muscle tone
- Changes in walking
- Orthostatic hypotension

Age Related Changes – Psychological

Fear of falling

- Decrease in activities
- Deconditioning
- Loss of independence

Changes in Mental Status

Alzheimer's Disease and Dementia

- Impaired judgment
- Poor reasoning
- Lost geographically
- Changes in perception
- Behavioral changes

Medical Conditional

Acute illness

- Infections
- Exacerbations of chronic illnesses

Cardiovascular problems

- Changes in blood pressure
- Heart failure
- Lightheadedness/dizziness
- Edema

Medical Conditional

Neurological/cognitive

- Gait disorders
- Parkinson's disease/Alzheimer's disease
- Strokes

Musculoskeletal

- Muscle weakness
- Arthritis – Decrease in physical activity
- Foot disorders

Medical Conditional

Gastrointestinal

- Diarrhea
- Nausea/Vomiting
- Incontinence

Extrinsic Factors

- Physical environment
- Assistive devices
- Footwear

Physical Environment

- Poor lighting
- Floors and stairs
 - Rugs/carpeting
 - Handrails
 - Spills/incontinence
- Bathroom
 - Doorways
 - Grab bars
 - Bathtubs/showers
- Bedside table
- Pets

Assistive Devices

- Canes
- Walkers
- Wheelchairs
- Elevated toilet seats
- Grab bars

Footwear

- Proper fit
- Slip resistant soles
- Low heels

Preventing Falls

- Ensure adequate lighting
- Eyeglasses – clean
- Proper footwear
- Non-slip shoes
- Use of assistive devices
- Provide assistance with transfers
- Ensure safety devices are in place if ordered
 - Alarms
 - Floor mats
 - Restraints

Care and Services that Matter



Accident Risk Evaluation

- Important to utilize the same Accident Risk Evaluation by all staff members upon admission and when change in status.
- Complete initial Accident Risk Evaluation within 24 hours of admission due to increased risk for falls (change in environment increases this risk),

Accident Risk Evaluation

Evaluation includes:

- Level of Consciousness / Mental Status
- History of Falls
- Contenance Status
- Vision Status
- Gait / Balance / Ambulation / Assistive Devices
- Use of Side Rails
- Medications
- Predisposing Diseases
- Smoking Status

Evaluation/Documentation

- Body systems assessed for cause (i.e., UTI)
- Control pain
- Family and Physician notification
 - Discuss “non-compliance” issues
- Re-assess Care Plan interventions, medications, environmental precautions, Resident/Patient monitoring

“AT FALL RISK”

- New or Re-admits
- Decline in condition
- Identify those Residents/Patients at higher risk for fracture due to conditions and diagnoses such as diabetes, osteoporosis, history of CVA

When to EVALUATE?

When to evaluate?

- Upon admission
- When transferred within the facility
- Change of status
- Following a fall or other related accident /incident
- Quarterly/Annually/In conjunction with the RAI
- When the IDT Feels appropriate

After the Accident/Incident

Incident / Occurrence / Exception / Change in Condition / Report is completed:

- Specific information (time, location, injury, potential causes, resident/patient statements, witness statements) – be thorough, be precise
- All actions conducted by the staff (contacted physician, contacted family, performed assessment, etc.)

After the Accident/Incident

- Continuous monitoring of resident/patient post fall for complaints, change in condition, behavior.
- Update Care Plan – which interventions need updating?
- Review patterns in falls – develop strategy to reduce future risk.

Clinical Management

- Minimize environmental hazards
 - Furniture placement, lighting, no clutter, clean up spills, no rugs, no mats
- Implement interventions to minimize injury (educate / follow up)
- Respond promptly to the fall or other accident/incident
- Shift report
- Manage family expectations (enlist their help; communicate)
- Physician notification

Clinical Management

- Therapy screen; evaluate if appropriate
- Side Rail Evaluation upon admission and in conjunction with RAI
- Appropriate care planning: manage fall risk / minimize injury
- Medication Regimen Review
- Blood pressure x 3 days post admission
- Comfort rounds (assess and address needs for pain relief, toileting, positioning)

Clinical Management

- Resident/Patient Check: Pain/ Potty/ Positioning/ Possessions
- Check: Telephone, Television, Tray Table Clean, Trash Removed, Tissue
- Bed in lowest position and proper working order
- Side rails in use and are in proper working order
- Gait belts for ambulating and transferring
- Walkers and wheelchairs are in good working order
- Surveillance

Integrating RCA

What is RCA?

As a reminder:

Root cause analysis (RCA) is a method of **problem solving** that tries to identify the root causes of faults or problems. A **root cause** is a cause that once removed from the problem fault sequence, prevents the final undesirable event from recurring. A causal factor is a factor that affects an event's outcome but is not a root cause. Though removing a causal factor can benefit an outcome, it does not prevent its recurrence for certain.

RCA is Systematic

To be effective, root cause analysis must be performed systematically, usually as part of an investigation, with conclusions and root causes that are identified backed up by documented evidence.

A team effort is beneficial in fall evaluation and reduction programs!

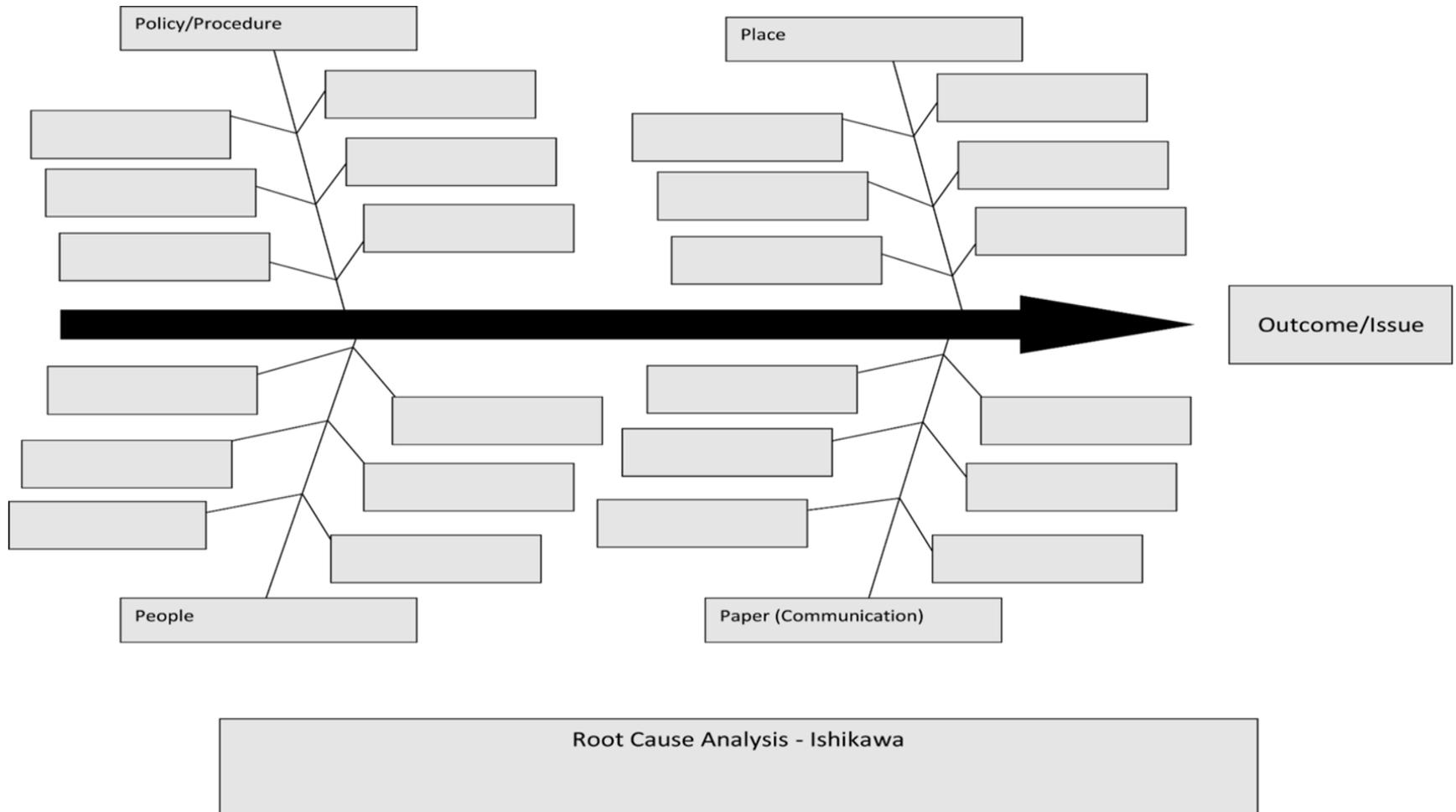
Timeline

To be effective, the analysis should establish a **sequence of events** or **timeline** to understand the relationships between contributory (causal) factors, root cause(s), and the defined problem or event to prevent in the future.

Considerations at a Glance

- Define the problem or describe the event factually.
- "Why" means "What were the factors that directly resulted.
- Identify harmful factors as possible "RCs."
- Identify corrective action(s) to prevent...
- Implement the recommended RC corrections.
- Gather data and classifying it along a timeline of events.
- Classify causes into factors that relate.
- If multiple root causes, reveal those clearly for later optimum selection.
- Identify solutions that to prevent recurrence.
- Identify other methods for problem solving and avoidance.

Root Cause Analysis - Ishikawa



What are the 4 P's

The 4 P's include:

1. Policy and Procedure
2. Place
3. People
4. Paper (communication)

What are the 5 W's

Understanding the 5 W's:

- who,
 - what,
 - where,
 - when, and
 - why (or why not)

Fall Care Plan Practices

Fall Care Plan Practices

Care Planning is a process that has several steps that may occur at the same time or in sequence. The following key steps and considerations may help the IDT develop the care plan after completing the comprehensive assessment.

Care Plans

Care Plans are important to help Residents Attain or Maintain...



Care Plan Orientation

PRIMARY:

- Resident Centered
- Respecting the resident's rights to decline treatment
- Preventing avoidable declines in functioning or functional or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in an end-of-life situation)

Care Plan Orientation

- Managing risk factors to the extent possible or indicating the limits of such interventions
- Addressing ways to try to preserve and build upon residents' strengths
- Applying current standards of practice
- Evaluating treatment of measurable objectives, timetables, and outcomes of care

Care Plan Orientation

- Offering alternative treatments as applicable
- Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities
- Involving resident and other resident representatives as appropriate

Care Plan Orientation

- Assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs
- Involving the direct care staff with the care planning process relating to the resident's expected outcomes
- Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting

Accident/Incident

Is the Accident/Incident Under SNF Control...
or not...?

Preventable or Not?

To determine if the event is adverse, meaning is it under the facility control? Was it foreseeable, predictable, able to be prevented?

One knows this only with investigation.

Base Regulatory Considerations

- Accidents and Supervision

PLUS

- Neglect – failure to appropriately supervise
- Failure to operationalize policy and procedure to prevent abuse, neglect
- Administration
- QAPI

Reporting Requirements

In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will:

1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than

Reporting Requirements

24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

Reporting Requirements

2. Have evidence that all alleged violations are thoroughly investigated.
3. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

Reporting Requirements

4. Report the results of all investigations to the administrator, or his or her designated representative, and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Fall Prevention Program

- Review Fall Prevention Program Policy
- Review Documentation required per program
- Review Interventions
- Review Huddle

Fall Prevention Program

POST FALL HUDDLE

Responding to a Fall

We call it the Post - FALL HUDDLE

All staff respond: Dietary, Nurses, CNA's,
Housekeeping, Maintenance, Therapy, Activities,
Social, Administration



What questions do we ask?

The 4 P's

- Position
- Personal needs
- Pain
- Placement



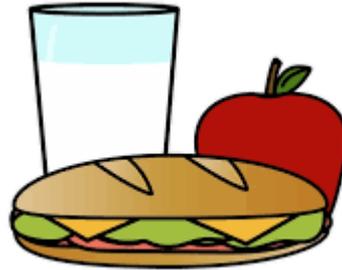
Position

- Where is the walker, the wheelchair?
- What position is the bed in?
- Where are the resident's shoes?
- What was their last activity?
- Who last saw this resident?



Personal Needs

- Hungry?
- Thirsty?
- Wet?
- Clothed?



Pain

- Is this resident in pain?
- Facial Grimacing?
- Location and severity?



Placement

- How was the resident placed in wheelchair?
- Is the wheelchair comfortable?
- Is the bed comfortable?
- Where is the call light?
- Where is the water pitcher?

POST FALL HUDDLE

- We must respond.
- We must discuss.
- We must intervene.



Summary

Summary

- In summary, the process to identify the risk of hazards and especially falls is a challenging one.
- We believe that with your facility system in place, open mindedness, and commitment to the overall safety and well-being of your residents that you can create, improve, and maintain excellence in the reduction of incidents and accidents especially falls.

Forms

- Policies
- Incident/Accident Form
- Post Fall Huddle
- Post Incident/Accident Investigation Form

Q & A

Questions???



Thank you
Incident and Accident Management



To learn more about this topic please contact Tamra M. Adrian, RN, HCRM, CDP, Director of Regulatory Services at tamra@rbhealthpartners.com
Click [HERE](#) for more info about this Presenter



You may also contact Robin A. Bleier, President with regards to this or other services at robin@rbhealthpartners.com or call us at 727.786.3032.
Click [HERE](#) for more info about this Presenter

Fall Prevention Program Post Test

NAME: _____

DATE: _____

1. The intent of the regulation is that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.
 - a. True
 - b. False

2. What 3 components contribute to a resident's fall?
 - a. Their physical condition
 - b. Their mental condition
 - c. Their environment
 - d. All of the above

3. List common risk factors for falls and interventions for each:
 - a. _____
 - b. _____
 - c. _____
 - d. _____

4. Medications may affect a resident's balance?
 - a. True
 - b. False

5. Intrinsic factors include:
 - a. _____
 - b. _____
 - c. _____
 - d. _____

6. Examples of extrinsic factors are: wet floors, canes, walkers, shoes and lighting?
 - a. True
 - b. False

7. If I lower my resident to the floor and they are not injured, I do not have to inform my charge nurse?
 - a. True
 - b. False

8. What is the name of your facility's fall prevention program?
9. If you find a resident on the floor, do you leave the resident alone and go get help?
[]YES []NO
10. How often does a Accident Risk Evaluation need to be completed on a resident?
- a. Upon admission
 - b. Quarterly
 - c. Annually
 - d. After each fall
 - e. All of the above
11. What should I do as a facility staff member as I pass a resident's room with a Star on the door?
- a. _____
12. Once the resident is secured what should happen next?
- a. _____
13. Witness statements should be obtained as soon as possible directly after an accident/incident, while memories are fresh?
- a. True
 - b. False
14. Safety/Adaptive equipment placement should be evaluated to be in place and functioning appropriately when?
- a. At the beginning of the shift
 - b. After transferring a resident from bed to chair
 - c. Before leaving the resident care area
 - d. When the resident returns to the facility
 - e. All the above
15. Fall prevention is the responsibility of whom?
- a. The Nurse Staff
 - b. The Administrator
 - c. Therapy
 - d. All Staff