Falls, Fines and Forms: A Nurse’s Guide to prevention, compliance and Documentation

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Objectives

- Understand Major fall risk factors and PREVENTION strategies
- COMPLIANCE: Identify regulatory pitfalls and fines related to falls
- Improve nursing DOCUMENTATION to support compliance and resident safety

Why falls matter:

- 60% of long-term care residents fall each year
- Falls are the leading cause of injury-related death in older adults
- Falls have an impact on several areas: hospitalization rates, loss of independence, survey citations, quality measures, etc.

Why falls matter

- The Human Impact: Falls in LTC facilities often result in severe consequences for our most vulnerable residents. Hip fractures, traumatic brain injuries, and other fall-related injuries can dramatically alter a resident's quality of life, leading to decreased mobility, increased pain, and loss of independence. For many older adults, a serious fall marks the beginning of a downward spiral in health and functioning that may never be fully recovered.
- The psychological impact: Residents who experience falls frequently develop a fear of falling that leads to self-imposed activity restrictions, social isolation, and further physical decline. This creates a dangerous cycle where reduced activity leads to muscle weakness and balance problems, paradoxically increasing fall risk.
- Regulatory and Legal Considerations: Kansas LTC facilities operate under strict federal and state regulations that mandate comprehensive fall prevention programs CMS requires facilities to assess each resident's fall risk and implement appropriate interventions. Failure to meet these standards can result in citations, fines, and potential loss of certification.
- Financial Implications: The economic burden of falls in LTC facilities is substantial. Direct medical costs include emergency department visits, hospitalization, surgical interventions, and extended rehabilitation services. For Kansas facilities specifically, falls can impact Medicare and Medicaid reimbursement rates through quality measures and star ratings. Poor fall prevention performance can affect a facility's ability to attract residents and maintain census levels, directly impacting revenue and sustainability.
- Quality of Care Indicator: Fall rates serve as a key indicator of overall care quality in LTC facilities. High fall rates often signal broader systemic issues such as inadequate staffing, insufficient staff training, poor care planning, or inadequate environmental safety measures.

Common Fall risk factors

- Intrinsic (resident specific): Weakness, meds, impairment of cognition, vision or hearing, incontinence or urgency, chronic illness, fear of falling
- Extrinsic (environmental or external): Floor clutter/hazards, poor lighting, unsafe transfers, improper footwear, broken equipment/grab bars, call light out of reach, poor room layout
- Medications: Psychotropics, diuretics, antihypertensives

Prevention Strategies

- Resident/Family interview at admission: what side of the bed did the resident sleep on prior to admit? How well does the resident sleep at night?
- Adequate staffing- not just in number but in behavior
- Toileting programs- must be individualized
- Proper footwear and mobility aides
- Interdisciplinary care planning
- Environmental checks
- Medication Reviews-utilize your pharmacist consultant
- Fall prevention training for all staff members annually with competency validation
- Lift team protocols for safe resident transfers and handling
- Communication tools (SBAR format) for reporting fall risks between shifts
- Family education programs about fall prevention strategies and risk factors
- Interdisciplinary team meetings weekly to discuss high-risk residents
- Shift huddles including fall risk alerts and prevention reminders
- Skin integrity monitoring to identify pressure areas that may affect positioning

Examples of Fall Interventions

•Medication review for fall-risk medications: (psychotropics, sedatives, antihypertensives, diuretics) by pharmacist
•Vision screening and referral to ophthalmologist for correctable vision problems
•Hearing assessment and hearing aid maintenance to improve communication and awareness
•Cognitive assessment to identify delirium, dementia progression, or other cognitive changes
•Orthostatic vital signs monitoring for residents on blood pressure medications
•Gait and balance assessment by physical therapy upon admission and with changes
•Footwear assessment to ensure proper fit, support, and non-slip soles
• Non-slip flooring in all resident areas, especially bathrooms and shower areas
•Adequate lighting
•Nighttime lighting: Night lights; motion-activated LED strips along pathways
•Grab bars installation in all bathrooms, showers, and beside toilets
•Bed height adjustment to lowest safe position (18-20 inches from floor)
•Clear pathways free from clutter, cords, and obstacles in rooms and hallways

Examples of Fall Interventions

- Bathroom door modifications ensuring doors open outward and have emergency release locks
- Shower chairs and benches with non-slip surfaces in all shower areas
- Raised toilet seats and toilet safety frames for residents with mobility limitations
- Handrails on both sides of all corridors and stairways
- Bed alarm systems for high-risk residents with individualized sensitivity settings
- Chair/wheelchair alarms for residents at risk of unsafe transfers
- Floor mats with sensors placed beside beds of high-risk residents
- Call light systems within easy reach and functioning properly at all times
- Assistive mobility devices (walkers, canes) properly fitted and maintained
- Hip protectors for residents with history of falls or hip fractures
- Anti-slip socks or footwear provided to residents, especially during transfers

Examples of Fall Interventions

- Toileting schedules based on individual patterns to reduce urgent bathroom trips
- Hydration monitoring to prevent dehydration-related weakness and confusion
- Pain management protocols to address pain that may affect mobility and judgment
- Sleep hygiene programs to reduce nighttime confusion and wandering
- Medication administration timing to minimize peak sedation effects
- Physical therapy interventions including strength training and balance exercises
- Occupational therapy for activities of daily living and environmental modifications
- Nutritional assessment to address malnutrition contributing to weakness
- Bowel and bladder management programs to reduce urgent toileting needs
- Wireless nurse call pendants for residents who are mobile but at risk
- Bathroom monitoring systems with privacy-compliant motion detection
- Video monitoring systems in common areas (compliant with privacy regulations)

*Note: “Send to ER for evaluation” is not an appropriate intervention

Compliance: F689- Accidents and Supervision

(Rev. 225; Issued: 08-08-24; Effective: 08-08-24; Implementation: 08-08-24)

§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. Must ensure environment is free of hazards
    - Adequate supervision- what does “adequate” mean?
        - 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.
    - Assistive devices must be used and maintained properly

What gets cited

- Repeat falls with no new interventions
- Incomplete post-fall assessments
- Care plans not updated- could lead to G level tag
- Lack of staff training
- No fall prevention in baseline or comprehensive care plans

Survey consequences

- Statement of deficiency
- Directed in-service training
- Civil Monetary Penalties –Fall-Related F-Tags That Trigger CMPs F-Tags:
    - F329 - Accident Prevention: Failure to ensure residents receive care to prevent accidents
    - F323 - Quality of Care: Failure to provide care that meets professional standards, including fall prevention
    - F385 - Quality Assurance: Inadequate quality assurance programs for fall prevention
  - Current CMP Penalty Amounts (2024)
    - Recent CMS proposals have significantly increased penalty amounts. A Per Day Instance CMP could be up to $25,847, with the largest Per Day penalty potentially reaching $3,488,400 if the non-compliance period extends over time.
  - CMP Structure:
    - Per Instance CMPs: Applied for each individual violation Per Day CMPs: Applied for each day a facility remains out of compliance Range: $1,192 to $25,847 per day or per instance (2024 rates after inflation adjustments) When CMPs Are Imposed for Fall-Related Issues CMPs may be imposed when facilities fail to:
        - Conduct adequate fall risk assessments (F329 violation)Implement appropriate fall prevention interventions (F323 violation)
        - Provide proper supervision for residents at fall risk (F323 violation)
        - Maintain safe environmental conditions (F329 violation)
        - Properly investigate and analyze falls (F385 violation)
        - Develop and follow individualized care plans addressing fall risks (F279 violation)
  - nearly 95% of facilities facing CMPs follow the hearing request process and receive a 35% penalty reduction

Legal consequences

- 💰 **Settlements & Verdicts**
- **Average settlements** for skilled nursing facility negligence (which includes falls):
  - $216,428 in 2018 → $251,296 in 2024 health.com+7consumershield.com+7ahrq.gov+7.
- Assisted living averages rose from $224K to $287K; independent living from $152K to $273K consumershield.com.
- From out-of-court claim resolutions, **88%** result in plaintiff compensation, averaging **$406,000** per claim medlegalpro.com+5oppenheimlaw.com+5pmc.ncbi.nlm.nih.gov+5.
- **Recent wrongful death case regarding post-fall sepsis settled for $500,00 in Kansas.**
- Notable juried verdicts:
  - ~$6 million awarded in recent cases involving fatal falls/neglect medlegalpro.com.
  - A California case in 2024 reached **$20.5 million** after fatal multiple falls nursinghomeabusecenter.com+1bbga.com+1.

Documentation:

Incident Reports- Key points

- Time, location and witness
- Description of resident's position, behavior, footwear, vital signs
- What was happening prior to or right after the fall?
- Notifications made- who was notified, by whom, how (phone call, fax, text message, etc)
- Outcome of assessment
- interventions

Post-Fall Assessment

- Pain, neuro, skin check
- Mobility and strength re-evaluation
- Environment at time of fall
- Contributing factors
- Check for current fall interventions- were they being followed? If so, were they effective?

Care plan and IDT follow - up

- Update fall risk score
- Add new interventions
- Review by therapy, nursing, activities
- Resident/family input
- Remove old interventions that are not effective or no longer appropriate

Documentation Do’s and Don’ts

- Do:
  - Be objective and complete
  - Include action taken and follow-up
  - Determine Root Cause and Record Intervention on Care Plan

- Don’t:
  - Use vague Terms (“found on floor”) without context
  - Don't Omit Facts- Every relevant detail must be documented, even if it seems unflattering or potentially problematic. Omitting facts can be more damaging legally than including uncomfortable truths.
- **Common Facts That Get Omitted:**
  - Call lights out of reach
  - Equipment malfunctions or unavailability
  - Resident's cognitive status or confusion level
  - Environmental hazards present at time of fall
  - Previous fall interventions that weren't updated

Documentation example

- Poor:
  - “ Resident fell. No injuries”
  - Strong:
    - “Resident observed sitting on floor at bedside. Alert, no distress. Pain 0/10. Neuro check in normal limits for resident. Prior to incident resident was resting in bed. Call light was not pressed but was within reach. Resident stated she was trying to get up but her socks slid. Socks appear to be grippy socks but the grip is worn off. New grippy socks provided to resident. MD and Family notified. Care plan updated”.

Case Scenario Review/Discussion

Margaret Thompson fall example review:

- What would you document? What would you change?

Key takeaways

- Prevent proactively
- Document defensibly
- Comply Consistently
- Every fall is a clinical and regulatory opportunity

References

- - CMS: Minimum Data Set 3.0 Manual
- - OIG: Skilled Nursing Facilities Fall Report (2022)
- - HHS: Nursing Home Compare Data (2024)
- - NPIAP: Pressure Injury Guidelines (2023)
- - CNA Aging Services Claims Report (2022–2024)
- - KDADS Facility Reports (2023–2024)
- - K.S.A. 60-513: Personal Injury Statute of Limitations
- - Button Law Firm: Falls in Kansas City (2024)
- - Nursing Home Law Center: Verdicts & Settlements (2024)
- - AP: $45M Settlement with Kansas Operator (May 2024)
- - Reuters: LaVie Bankruptcy Filing (June 2024)
- - U.S. News: Nursing Home Understaffing (March 2024)

Questions?

Thank you!