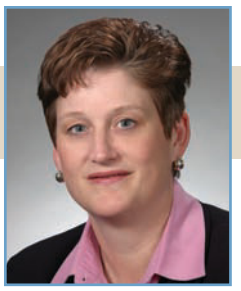
## Legal Issues



By Janet K. Feldkamp, JD, RN, LNHA

# What to Consider When Addressing Resident Falls Within Your Facility

Falls are among the most frequent accidents in nursing homes and assisted living facilities, and they can be among the most difficult to prevent.

Routine assessment of risk must be an active component of a strong fall-prevention program. After a resident has been identified as at risk of falling, the facility must not only implement adequate fall-prevention measures, but also develop procedures to ensure that interventions such as alarms are always functioning properly.

Civil litigation and survey citations can occur even from a fall that your facility believes was unavoidable. The Health and Human Service's Departmental Appeals Board (DAB) has recently upheld findings by the Centers for Medicare & Medicaid Services of facilities' noncompliance with regulations—at the level of "immediate jeopardy" to residents—when considering some of those facilities' fall-prevention interventions.

In April, the DAB upheld a finding of immediate jeopardy and the imposition of civil monetary penalties as a result of a fall by an 85-year-old woman who suffered from dementia, congestive heart failure, a history of cerebrovascular accidents, and osteoporosis (Dec. No. 2314, April 12, 2010). The facility had assessed the risk and documented that the resident required extensive assistance for moving in bed, transfers, dressing, toileting, and personal hygiene. Nurse's notes also indicated that the resident suffered impaired safety awareness and judgment and that she tended to fidget while receiving care.

During the incident in question, a nurse's aide was transferring the resident from her wheelchair to her bed using a stand-up lift, when the resident moved and slid out of the chair and onto the floor. When interviewed about the incident, the nurse's aide indicated that the resident had "wiggl[ed] until she slid out of the wheelchair." The resident's arm became lodged in the wheelchair, resulting in a fractured wrist and a skin tear on her thigh.

The DAB noted that, while the accident did not by itself prove that the nurse's aide—the facility—had failed to provide adequate supervision of the resident during the transfer, the circumstances surrounding this fall supported the CMS's position that the nurse's aide was at fault during the transfer.

The DAB highlighted the aide's statement suggesting that some time had passed between the time the resident started "wiggling" and when she fell to the floor. According to the DAB, this suggested that the aide could have done something to prevent the fall after the resident started moving but that she failed to respond quickly and appropriately.

Nevertheless, the DAB also noted that an inference of inadequate supervision is reasonable even if undisputed evidence shows that the staff member tried to secure the resident when she began to fall.

Because the circumstances surrounding the fall supported the CMS position, it was the facility's burden to introduce evidence to show it had, to the contrary, provided adequate supervision of the resident's transfer. The DAB held that the facility was obligated to tell what steps the aide took to conduct the transfer safely and why those steps were adequate.

Although the facility investigated the fall, the DAB found that the facility did not try to ascertain what procedures the aide followed during the transfer and the extent to which those procedures, or the lack thereof, may have contributed to the fall. The DAB held that the absence of evidence concerning what took place during the transfer should be construed against the facility's position, not that of the CMS. Therefore, the DAB upheld the finding of a deficiency at the level of immediate jeopardy.

This case illustrates that falls often result in a presumption of inadequate supervision, which the facility then bears the burden of rebutting. Therefore, facility administrators should ensure not only that staff members are adequately trained to prevent falls but that those investigating the circumstances after an accident know to investigate and document each intervention that staff members employed during the incident. This will maximize the facility's likelihood of being able to show that it adequately supervised the resident and that the fall could not have been avoided.

### Alarms Need Monitoring, Safeguards

Alarms are often employed in fall-prevention programs. However, a recent DAB case (Dec. No. CR2108, April 7, 2010) illustrates the importance of careful and consistent monitoring of alarms that ensures proper functioning and use.

In this case, a facility appealed a finding of noncompliance at the immediate-jeopardy level and civil money penalties in excess of $44,000 after the CMS concluded that the personal alarms of three residents assessed as at risk of falling were either not in place or not functioning properly. One of the residents' alarms, although connected to the resident's bed, failed to sound when the woman rose from her bed, made her way to the hallway, and fell. Five days later, surveyors observed the resident in bed but with the alarm cord disconnected from the alarm box.

The surveyors observed two other residents without intact tab alarms, which their care plans required. In addition, the surveyors noted that the facility did not maintain a readily accessible master list of all of the facility's residents who wore alarms. The surveyors also found confusion among the staff members as to where the monitoring of alarms was documented in resident records.

As the DAB noted in its decision, providing a resident with an alarm that fails to function properly may put the resident in greater jeopardy than if the resident had not been supplied with an alarm. The DAB observed that because facility staff members depend upon alarms to alert them that a resident is attempting to move about, the devices are used to enhance, or in some instances to substitute for, direct supervision of residents who are at risk of falls. Therefore, the DAB held that specific measures should be employed to ensure that the alarm system is used in the most effective manner possible.

This decision sets forth specific measures that facilities should employ, including maintaining a master list of residents who wear alarms so that facility staff members do not have to consult individual charts for that information. In addition, facility staff should be specifically assigned the responsibility of monitoring residents with alarms to ensure that the devices are properly functioning and in place.

The daily challenge of maintaining resident safety is difficult but vital for facilities to manage. Many residents are admitted to care facilities following falls in the community. Comprehensive fall-prevention programs that are part of the facility culture are important to maintaining a daily awareness of accident prevention. Without such a comprehensive program that begins at admission and is implemented consistently, facilities place themselves as increased legal risk of regulatory citations and sanctions and civil litigation.

*This column is not to be substituted for legal advice. The writer,* JANET K. FELDKAMP, *practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.*

## Medical Expert Perspective

Many falls result in settlements and judgments against nursing facilities. It is important to document both fall-risk assessment and care planning to prevent falls. After a fall or near-fall, it is critical to do a clinical assessment, perform alert charting and neurologic checks if there was a chance of head trauma, and conduct an interdisciplinary evaluation of strategies to prevent additional falls. In some cases, taking additional measures should not wait until a formal team review but should be implemented immediately.

Clearly, alarms cannot prevent falls unless the devices are functioning, the resident does not disable the alarm, and all staff make it a priority to respond immediately when the alarm sounds. Even when those conditions are met, the devices cannot prevent all falls. While physical restraints are known to be associated with injuries more serious than those sustained by unrestrained patients, there may be clinical scenarios where—while not ideal—restraints still need to be considered.

Whatever the clinical decision, it is important to document discussion with the responsible party and include risks, benefits, alternatives, and clear documentation of informed consent (or refusal). Both physicians and nonphysician practitioners should take part in these decisions, and they shouldn't consider calls about falls to be a nuisance. Just as a fall with a hip fracture can represent a catastrophic, preterminal event, prevention of such a fall can be a huge kindness to a patient.

**—Karl Steinberg, MD, CMD**
**Editor in Chief**