Q1: If there is another fall with or without injury during the 275 day time period does the clock re-start for the 275 days?

A1: Both Fall measures use a lookback scan to determine if a fall has occurred and to count that fall in the QM calculation. The Quality Measures Manual V14 indicates, *"Include the target assessment and all qualifying earlier assessments in the scan*." It goes on to state that, "*The purpose of the look-back scan is to determine whether such events or conditions occurred during the look-back period. These measures trigger if the event or condition of interest occurred any time during a one year period. A 275-day time period is used to include up to three quarterly OBRA assessments. The earliest of these assessments would have a look-back period of up to 93 days, which would cover a total of about one year."* Since this is the case, with each fall that is recorded on the MDS, the lookback period essentially starts again because that fall will be included in the lookback scan of the next target assessment(s) until a year has past since it was captured.

Q2: When someone dies, how long does it take for the fall with major injury fall off?

A2: See answer to number Q1. If the Discharge assessment is the target assessment and a fall happened in the lookback scan period, then the fall will continue to affect the QM until the discharge is no longer the target assessment.

Q3: Only the major injury is included in the 5 star and QM on care compare? I am trying to figure out where J1800 info appears?

A3: Yes, J1900C impacts QM N013.02 Percent of Residents Experiencing One or More Falls with Major Injury which affects the 5-Star rating. J1800 impacts QM N032.02 Prevalence of Falls which does not impact the 5-satr rating. However, both falls' measures are included in the CASPER report.

Q4: IF someone falls 3/1, MDS ARD is 3/2 captures the fall. But if a 2nd MDS is done on 3/30, and no falls occurred between 3/2 ARD and 3/30, will it still capture the fall on QM?

A4: Yes. See answer to Q1.

Q5: Is there an industry-standard falls assessment tool that is recommended?

A5: Renee presented some valuable resources from the CDC's Stopping Elderly Accidents and Injuries or STEADI resource page. That would be a great place to start. You will find an Algorithm for Fall Risk Screening, Assessment, and Intervention tool at the following link.
https://www.cdc.gov/steadi/materials.html

Q6: Should a fall w/ a subluxation (partial dislocation) be considered a major injury?

A6: Yes. The definition of major injury is, "Bone Fractures, **Joint Dislocations**, Closed Head Injuries with altered Consciousness and Subdural Hematoma. Note that neither the RAI Manual nor the MDS items et make any further qualifications the individual parts of this definition other than to list what is considered not a major injury. Always remember, *"If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Quality Improvement and*

*Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, the assessment **must be modified** to update the level of injury that occurred with that fall."*

Q7: Does major injury include all fractures including facial fracture and finger fractures no matter whether they affect their ADL functioning or not? Are finger, toe, elbows or wrist considered major injury? Or if it did not cause a decline is that not a major injury?

A7: Yes. See answer to Q6.

Q8: J1900C - Major injury: Head Injury WITH altered consciousness - Does this mean we don't have to code if there was no change in level of consciousness?

A8: As with all coding of items on the MDS there is a certain amount of clinical decision making that must be taken into account. That said, for this item specifically, consider that one of the other example major injuries is a subdural hematoma. This is also a closed head injury that may or may not have altered levels of consciousness. The list of injuries is not exhaustive but is broad enough to assist in clinically determining if an injury is major.

Q9: What is the best approach to take regarding residents with behaviors who slide themselves to a lower service? While they are not true falls they have to be coded as a fall. Also why is it that if a staff acted promptly and was able to prevent a fall, it is still considered a fall? It does not seem fair to the facility. Why was the fall definition so altered? Most of this just results in more fines and penalties or the facility not being able to avail of the QASP.

A9: The issue really is fall prevention. Remember that the definition of a fall starts by indicating that a fall is an, "***Unintentional*** *change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat)."* The movement of a resident who intentionally slide themselves to a lower surface may not be considered a fall at all. The critical thinking and clinical analysis piece here are to decide the intentionality. Once the IDT determines that then they can determine if a fall, as defined in the RAI Manual, has occurred.

As for the issue related to staff intervening in a fall, remember that the intent of the falls items on the MDS are to alert staff to resident who have fallen or at risk for falls, to determine why that resident is uniquely predisposed to falling and to implement interventions to try to keep the resident from falling. If a resident falls but is intercepted, not only does the RAI Manual require this to be coded as a fall, more practically speaking, from an assessment stand point, if we were not alerted to this situation by calling it a fall, then we may not have the appropriate interventions in place to prevent the resident from a non-intercepted fall at which time there may be other serious consequences. Read the Item Rationale items on page J-30, 31 and32 for the RAI Manuals more specific guidance in this area. These are helpful guidelines for why we must be ever alert to residents at risk for falling.

Q10: Re: Major Injury coding - Do we code Head Injury if NO altered consciousness occurred? example: an obvious head hematoma but no changes in LOC.

A10: See answer to Q8.

Q11: Many falls occur because residents simply do not wish to comply with their plan of care even when the facility exhausts all efforts. Will the MDS be addressing that? The facility cannot force compliance

and yet if they fall it goes against the facility. Most of what is being talked about by Renee is not new , it's being done. It's too one sided. The barriers at the facility level need to be looked into.

A11: See answer to Q9. Also, as you are aware, MDS item E0800 addresses the issue of rejection of care. The Planning for Care section of these coding guidelines on page E-14indicate.

Planning for Care

• *Evaluation of rejection of care assists the nursing home in honoring the resident's care preferences in order to meet his or her desired health care goals.*

• *Follow-up assessment should consider:*

— *whether established care goals clearly reflect the resident's preferences and goals and*

— *whether alternative approaches could be used to achieve the resident's care goals.*

• *Determine whether a previous discussion identified an*

objection to the type of care or the way in which the care was provided. If so, determine approaches to accommodate the resident's preferences.

Clearly, the IDT must do everything it can in conjunction with the resident's wishes to address this issue even when the resident has legitimate reasons for rejecting care. Remember that the QMs are not intended to be punitive but a guide for Quality improvement initiatives. Documentation is key in each these situations.

Q12: Question on a different QM: High-risk Pressure Ulcer Long-Stay QM, if the resident only had 1 episode and was noted with a pressure ulcer in a Quarterly on 2/1/21, will a completion of a Significant Change on 3/30/21 showing that the ulcer has healed remove the resident from the QM? Or will it still count since it is an assessment within the target period?

A12: The pressure ulcer must have been coded on the target assessment. The target assessment represents the resident's status at the end of the episode. If the SCOS you mention is the target assessment, then the pressure ulcer should be removed as affecting the QM. The high-risk pressure ulcer does not use a lookback scan.

Q13: How can I get one of the color coded MDS?

A13: Contact Tricia Wood at twood@broadriverrehab.com or Randy Wadley at rwadley@broadriverrehab.com

Q14: We developed our own fall assessment tool from the STEADI and other tools. Are you aware of surveyors having any issue with this?

A14: That is great! STEADI is a CDC tool and can be used as a guide either in current form or as a tool to further develop your own materials. We have not heard of an "issue".

Q15: What are your thoughts on use of bed and wheelchair alarms. Does it really help to reduce falls?

A15: Currently there is very limited evidence that alarms reduce fall risks. One useful tool to assess the current impact in your communities would be the Critical Element Pathway for restraints. All pathways can be found HERE-Nursing Homes | CMS

Q16: I was under the impression if a person who had a fall with a major injury and they are within the 275 days then the month after they die it falls off the CASPER?

A16: The fall will continue to affect the QM as long as the sample time period, or target period, includes the target assessment. If I use 6 months for my CASPER, then if the target assessment is within that timeframe, it will show up as affecting that report. For Care Compare and 5-Star, if the target assessment is within one of the 4 quarters being reported it will continue to affect the QM.

Q17: I have had 2 patients with nasal cartilage fractures r/t falls. Because they are not bone fractures, are they still coded as major injuries?

A17: Not according to a strict interpretation of the RAI manual's definition of a major injury.

Q18: Falls that happened prior to admission and coded in J1700 is not part of the numerator correct?

A18: Correct. Falls that are coded in J1800 and J1900 must have occurred Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent.

Q19: If the physician documents that there is a presumed major injury but does not order actual diagnostics, should it still be coded?

A19: Both examples 4 and 5 that address this particular issue, offered on page J-35 of the RAI Manual, rely on diagnostic s for the coding choices. I am inclined to follow those examples. How can you know definitively, except possibly with some joint dislocations, without diagnostics if any of the listed major injuries occurred? Also, modifying the MDS in the future related to major injuries relies on diagnostics as well (See answer to Q6).