Overview of ODH RCF Rules on Incidents and Falls

Key Regulations:

- **Ohio Administrative Code (OAC) 3701-16** governs incident management in RCFs.
- Facilities must:
    - Immediately respond to and document **any incident** affecting health/safety (including **all falls**, with or without injury).
        - Yes! If a resident "slides out of their chair"- this is an incident.
    - Notify the appropriate medical personnel and responsible party.
    - Do not ever say in the chart "left a note in the binder for next MD visit"- notifications are expected to be immediate.
    - Initiate an internal investigation and **modify care plans** as needed.
    - Maintain documentation that shows **timely intervention** and **follow-up**.

Surveyor Expectations:

- Surveyors will check:
    - Was the fall documented properly?
    - Was a timely assessment performed?
    - Were care plans or interventions updated?
    - Were similar past incidents addressed?

Fall & Incident Response Process

Step-by-Step Nurse Actions:

Ensure Safety & Provide Care

- Assess for injuries and stabilize.
- Notify provider and resident representative immediately.
    1. Notify any other providers that see the resident- therapy company, hospice company, if they are on Medicaid ensure Medicaid is notified.

2. **Complete Incident Report**
    - Accurate, objective documentation (time, witnesses, location, circumstances, vitals, neuro checks).
    - Detail any immediate interventions.

3. **Begin Post-Fall Assessment**
    - Determine contributing factors (environmental, behavioral, medical, etc.).
    - Use standardized tools (e.g., Morse Fall Scale).
4. **Update the Care Plan**
    - Include new or revised fall-prevention strategies.
    - Document any changes in supervision, mobility assistance, or equipment.

3. Fall Risk Assessment & Prevention

When to Assess:

- On admission
- After a fall
- After a change in condition or medication
- At regular intervals (as defined by policy or ODH requirements)

Risk Factors to Consider:

- History of falls
- Gait or balance issues
- Cognitive impairment
- Medications (e.g., sedatives, diuretics)
    - Keep an eye on this when a resident is put on a new medication! Trazodone is a big one.
- Environmental risks

Preventive Interventions:

- Scheduled toileting & rounding
    - *Number one reason for falls is the resident not being frequently toileted!

- Use of mobility aids
- Low beds, floor mats, and proper footwear
- Staff education and assignment adjustments
- Bed/chair alarms when appropriate—with staff accountability for response

Resident Alarm Use and Documentation Guidelines:

- If a resident who uses an alarm falls, be sure to document the following:
    - That the alarm was on at the time of the incident.
    - That the alarm was functioning properly.
    - That you tested the alarm and confirmed it was working.
- If the alarm was **not** working, different documentation procedures must be followed (document accordingly and report).
- For residents with alarms, ensure the following preventative steps are taken:
    - Batteries are checked regularly and replaced as needed to keep the alarm operational.
    - The alarm is clearly noted on the aides' assignment sheets.
    - The alarm is included as part of the resident's care plan.
    - When transferring the resident (e.g., from wheelchair to bed), the alarm is properly managed and maintained during the transfer.

4. Documentation & Legal Readiness

What Must Be Documented:

- Full details of the incident and response
- Notifications made (provider, POA, supervisor)
    - In this situation it is best to use names. Don't just say MD, POA or DON. Say Notified Dr. Sk Jain, POA Mrs. Smith and Director of Nursing Joanne Nelson, LPN.
- Post-fall assessments and results
    - Facilities generally follow a structured schedule for monitoring vital signs and neurological status after a fall.

- For falls involving head trauma or those that are unwitnessed, vital signs and neurological checks are usually performed every 15 minutes for the first hour (4 checks), then hourly for the next 4 hours, and subsequently every 2 to 4 hours, continuing for up to 72 hours.
- For witnessed falls without a head injury, regular documentation is still maintained, often with checks at least once per shift throughout the 72-hour monitoring period.
- Standard practice includes continuous monitoring for any signs of deterioration, such as changes in pain levels, bruising, mobility, or cognition, throughout the 72 hours following the fall.
- Immediate notification of the resident's physician and decision-maker is required. Families are typically kept informed and updated throughout the 72-hour period, especially after serious falls. Don't just call the family at the time of incident- update them more often!

Why the 72-Hour Monitoring Period?

- The 72-hour observation window aligns with national guidelines (such as AHRQ's On-Time Falls program) and long-term care accreditation standards. This timeframe helps ensure that any delayed complications—like internal bleeding, swelling, or neurological decline—are detected early and managed appropriately.

Summary Checklist for Documentation and Observation

Timeframe	**Action**
Immediately	Record the fall, notify physician and family, begin vital sign and neuro checks
First 24 hours	Continue scheduled checks; more frequent if fall was unwitnessed or involved head trauma
Up to 72 hours	Ongoing observations (vitals, pain, skin condition, cognition), update care plan
Throughout	Provide regular updates to family and physician; complete root-cause review and prevention planning

Bottom line: *While Ohio law may not explicitly state "72-hour documentation," standard practice and federal/state survey expectations clearly require consistent, documented monitoring for 72 hours after a fall. Facilities must support this with updated care plans, ongoing behavioral and clinical monitoring, and thorough communication with all parties involved.*

Why It Matters:

- ODH survey teams use documentation to determine if care standards were met.
- Incomplete or delayed documentation can lead to citations—even if care was delivered.
- Accurate records protect both the resident and the nurse legally and professionally.

5. Root Cause Analysis & Follow-Up

Purpose:

- Identify **underlying trends or system failures** (e.g., staffing gaps, timing of falls, missed alarms).
- Create action plans (e.g., more supervision, staff education, environmental modifications).

Nurse Role:

- Participate in **fall review meetings or huddles**.
- Share observations about high-risk times, behaviors, or missed care.
- Help implement revised protocols or interventions.

6. Staff Education & Documentation: "If You Don't Document It, It Didn't Happen"

Why It Matters:

- **ODH surveyors will not accept a note that simply says "education provided."**
- **If you document that staff were educated after a fall or incident, be prepared to prove it.**
- **Surveyors may ask: *"Show me the education you provided to the staff member."***
  If you don't have proof—it didn't happen.

Acceptable Ways to Document Staff Education:

1. **Signed Education Form (Strongly Recommended):**
    - **Prepare a printed staff education sheet summarizing the content discussed (e.g., fall prevention, alarm response, post-fall care).**
    - **Have the staff member sign and date it.**

- **Place a copy in:**
  - **The resident's chart (to show the education was related to that resident)**
  - **The staff member's file (to show accountability and HR compliance)**

2. **Assignment Sheet Notation:**
   - **If you use daily or shift assignment sheets, write a brief but specific notation of the education provided.**
   - **Example: "Educated CNA Jane Doe on Mr. Smith's toileting schedule and fall risk protocol."**
   - **Ensure the sheet is retained and accessible for review.**
3. **In-Service Logs or Group Training Records:**
   - **For team-wide education, use in-service attendance logs with:**
     - **Date and time**
     - **Topic covered**
     - **Signature of attendees**
     - **Printed name of educator and materials used (handouts, posters, etc.)**
4. **Electronic Medical Record (EMR) Documentation:**
   - **If your EMR allows, attach or link the signed education form to both the incident report and staff training logs.**
   - **Avoid generic statements like "staff re-educated"—instead, reference what specifically was taught.**

Key Takeaway:

Saying you provided education isn't enough. If you don't document it clearly—and if you can't show the physical proof—a surveyor will consider it as though it was never done.

Documentation should always:

- **Be specific**
- **Include signatures/dates**
- **Be easily retrievable (in chart, staff file, or assignment log)**

Conclusion & Key Reminders

- Every fall is a **reportable incident** under ODH rules—even without injury.
- Nurses are responsible for **timely assessment, documentation, and care planning**.
- Clear and complete documentation = regulatory compliance and resident safety.
- Prevention isn't one-size-fits-all—**risk factors must be individualized**.

7. Immediate Intervention Means Now — Not Tomorrow

What "Immediate" Really Means:

- **"We'll call therapy tomorrow" is not immediate.**
- When a resident experiences a fall or incident, the intervention must:
    - Be initiated **right away**
    - Be clearly defined (e.g., "staff to assist with toileting every 2 hours" or "bed alarm activated")
    - Be **communicated immediately** to everyone involved in care

What Must Happen After a Fall:

Initiate the Intervention Now

- If the resident needs therapy, start with **range-of-motion support**, increased supervision, or a fall-monitoring log **today**.
- If the resident needs assistive devices or new schedules (e.g., toileting plan), that must be put in place before the end of the shift—not the next day.

Update the Care Plan

- Yes, it's a lot of work—but it's **non-negotiable**.
- Care plans must reflect:
    - The fact that a fall occurred
    - What caused or contributed to it (if known)
    - What new strategies are now in place
- ODH surveyors **will check** if the care plan was updated to reflect the intervention.

Communicate to All Staff

- If only one person knows about the new intervention, the resident remains at risk.
- You **must pass it on**:

- **Write it on the assignment sheet** (clearly and legibly)
- **Announce it in shift huddles or report**
- **Include it in daily clinical notes** and **alert other departments if needed** (e.g., therapy, dietary)

🧠 Example: What Not to Do vs. What to Do

❌ Ineffective Response	✅ Proper Response
"Plan to call therapy in morning."	"ROM exercises initiated today. Therapy referral sent. Staff to ambulate resident with walker every shift."
Documented intervention but told no one	Noted intervention on care plan, assignment sheet, and discussed in evening huddle
No care plan update until next week	Care plan updated before end of shift with fall risk review and new plan added

Key Takeaway:

A fall intervention that isn't implemented, shared, and documented right away is a missed opportunity—and a surveyor will see that.

You must:

- Act now
- Update the care plan now
- Communicate now
- Document clearly in multiple places

Incident Review Expectations for Executive Directors and Administrators

Reviewing incident reports should be your top priority at the start of each day. It's essential that you're aware of every incident that has occurred to ensure:

- Proper steps were taken
- Immediate interventions were implemented
- Appropriate parties were notified

Each incident report should include the **Charge Nurse's signature**, the **Director of Nursing (DON)'s signature**, and the **Administrator and/or Executive Director's (ED) signature**.

Take an active role—be part of the solution. Make sure you **document as you go**.

Do not sign off on any incident unless it is 100% accurate. If there are any discrepancies or errors, this is a valuable opportunity to **educate the reporting nurse** and ensure best practices are followed.

Including resident identifiers like room numbers and initials in fall logs or incident logs may seem like a small step, but it can save a lot of time and frustration down the road.

Here's why it matters:

- **Surveyor Expectations:** Surveyors need to track and follow up on incidents quickly. If identifiers are missing, they'll ask for clarification — which can slow things down and potentially raise unnecessary concerns.
- **Internal Clarity:** When you or a coworker review the log later — especially weeks or months after the fact — having clear identifiers helps jog your memory and connect the dots more efficiently.
- **Accountability:** Including this information supports thorough, transparent documentation — something surveyors always appreciate.
- **Efficiency:** It reduces time spent during audits and prevents duplicate efforts trying to figure out who was involved.

Best practice: Use the resident's room number and initials (e.g., "R.101 – J.S.") to maintain clarity while respecting privacy and remaining HIPAA-compliant.

It's a simple habit that benefits everyone. By documenting it right the first time, you're making the process smoother for yourself, your team, and the surveyors

Falls are the leading cause of litigation in long-term care settings. For this reason, nurses, directors of nursing, and administrators must not take shortcuts when it comes to fall prevention policies, documentation, or resident care practices. Comprehensive assessment, individualized care planning, staff training, and consistent follow-through are essential to both resident safety and legal protection.