**Sustaining Quality:**
Reducing Fall Risk in Senior Living Communities

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- Has 33+ years in HC safety/risk (28+ years in post-acute care)
- Serves on the AHCA Professional Development Work Group
- Is a former corporate safety director for several LTC companies
- Spent his career developing risk & safety strategies, programs & solutions
- Is a founding member of the Direct Supply-sponsored Loss Prevention Forum

1. **Introduction**
2. **Claims, Costs, Considerations**
3. **Assessments and Interventions**
4. **People, Technology and Strategies**
5. **Quality Assessment Performance Improvement**

**Falls Session Agenda**

**Bloom's Taxonomy of Action Verbs**

Participants will be better able to:

1. **NAME** (Knowledge) ... To remember previously learned information
2. **EXPLAIN** (Comprehension) ... To demonstrate an understanding of facts
3. **CHANGE** (Application) ... To apply knowledge to actual situations

**Disclaimer**

The materials, comments and other information contained in this presentation are intended to provide general information but not advice about certain regulations and initiatives.

This information is not and not intended as legal or other advice and each situation may vary depending on the particular facts and circumstances.

You should not act upon this information without first consulting with qualified legal counsel.

Thank You.

**Objectives**

1. **Introduction**
2. **Claims, Costs, Considerations**
3. **Assessments and Interventions**
4. **People, Technology and Strategies**
5. **Quality Assessment Performance Improvement**

"HELP, I'm Falling Into Financial Burden From Falls!"
1. **How BIG is the “falls” problem?**

- **2012** = $30 B
- **65+** = 1 in 3 fall
- **20-30%** < morbidity and mortality
- **65+** = Hospitalized 5x for falls than other causes

*Actual direct costs but not long term disabilities, lost wages, quality of life Δ*

2. **How do these COSTS break down?**

1. Increase rapidly with age
2. Higher for women than for men (both fatal and nonfatal)
3. Costs for women* = 2–3x’s higher** than the costs for men

* 58% of older adults  ** based on 2000 medical costs

3. **TYPE of fall-related injuries** (in 2012 dollars)

1. Av. hospitalization = $34,294
2. 44% of direct medical costs = hip fractures
3. Hip fractures = most serious and costly fracture
4. Fractures (nonfall injuries) = most common [(33%) & costly (61%)]
5. 78% of deaths & 79% of costs = TBI and lower extremities (hips??)

*Traumatic brain injuries

4. **What do other say?**

1. Most claims are settled
2. Large Corporation’s Experience:
   a. $137K av. spent to “settle” falls claims
   b. 41 claims settled 9/30/2011 to 8/31/2014
3. Residents that fall = 18% / month (National LTC av. ≈ 20%)

5. **What are they worth?**

1. (03/23/02) **$1.99 million verdict** … struck her head … died 6 days after admission. Assessed as “high risk for falls” … failure to supervise … transported to hospital 10 hrs. after fall
2. (date unpublished) **$200,000 settlement** … 80-yr-old NH resident … died < 1 month after she fell … frx. femur … alarm NOT turned on
3. (date unpublished) **$862,500 settlement** … subdural hematoma … 76-year-old AL resident … fell … struck her head

Status: Dementia, required assistance with mobility, unsteady gait … walker/wheelchair. Passed 11/23/11; Death Certificate: *complications from L hip fracture due to a fall on 11/17/11 as immediate cause of death*
Demand $1.1 million; Settlement $127,500

Status: Osteoporosis, syncope, hypertension, depression, hyperlipidemia, peripheral neuropathy, history of hip fxr, chronic hip/leg pain, osteoarthritis of knee and hip. Passed 10/23/08. : Death Certificate: complications of R femur fxr due to a fall as cause of death. **Arbitration Verdict:** $195,475
6 b. SO, what is a claim worth?
NO average settlement
NO simple "approximate number"

What actually determines how much, if any, you’re going to pay?

1. Facts
2. Medical expenses
3. How many next of kin
4. Available insurance coverage
5. Time between accident and death

The Plaintiff Must Prove:

1. Professional **DUTY** owed to the resident
   
   *Dignity, Safety, Standards of Care*
   
2. **BREACH** of that professional duty
   
   *Elopement, Fall, Infection, Weight Loss*
3. **INJURY** caused by the breach
   
   *Malnutrition, Bedsores, Fracture, Death*
4. Resulting **DAMGES**
   
   a. Noneconomic loss (pain, suffering)
   b. Economic Loss (lost wages, related health care costs)

**Claim Evaluations Basics**

**Claim**

**Evaluations**

**Basics**

**US Legal System**

**Plaintiff**: accuser, complainant, litigant, applicant, pretender
**Defendant**: perpetrator, offender, respondent, suspect, culprit

What is a claim worth?

- **Facts**
- **Medical expenses**
- **How many next of kin**
- **Available insurance coverage**
- **Time between accident and death**

**Designed to**:

- Resolving the dispute without going to jury trial
- Encourage extensive discovery and negotiations between adversarial parties

**Four Elements**

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**As Taught by Plaintiff Attorneys**

**Signs of Nursing Home Abuse and Neglect:**

1. Bedsores
2. Malnutrition
3. Dehydration
4. Broken Bones
5. Unexplained Injuries
6. Unexpected Deaths

**A Caution**

"Fear of Falling"

- **WHAT:**
  
  A lasting concern … can lead to an individual avoiding activities that he/she remains capable of performing

- **WHO:**
  
  - 46% of NH residents
  - More women than men
    - Underreported by men?

- **WHEN:**
  
  - Post-fall
  - Age = 80+
  - Visual impairment
  - Sedentary lifestyle
  - Lack of emotional support

**Claim topics we won’t discuss**

1. Tort Reform?
2. Toughest states?
3. Labor hours involved in costs?
4. Hard or Soft Med Mal insurance market?
5. Will a Dem or Rep White House or Congress make a difference?
"Cycle of Fear"

FALL(s)

Fear of falling
Restricts activity

Physical capabilities reduced
Restricts more activities
∴ more impaired physical capabilities

Is the is "Cycle of Fear" reversible?

Falls and the Dignity of Risk

What Changed?
Was it worth it?

How did Ruth succeed?

1) She and her healthcare Team had a clear purpose
2) They were committed to that purpose
3) They consistently followed through
4) They had the resources (time, training, tools)

SUSTAINING QUALITY:
Reducing Fall Risk in Senior Living Communities

1. Introduction
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HELP, I’m Falling Into Financial Burden

What is the one thing, if you could change it, that would have the greatest impact on reducing falls in your communities?

FUNDAMENTALS of “Risk”

What we’re use to:
1. Risk
2. Risk Assessment
3. Risk Management
Some newer ideas:
1. Risk Benefit
2. Risk Enablement
3. Risk Enablement Plans
SIDEBAR: Assess My Mom

“Elinor Miller, 83 years old, talked herself out of a speeding ticket by telling the young officer that she had to get there before she forgot where she was going.”

Multi-factorial Assessment Process

1. Focused History
2. Physical Examination
3. Timed Up-and-Go Test
4. Orthostatic Hypotension
5. Where do you find Clinical Practice Guidelines?

Clinical Practice Guidelines

- American Medical Directors Association (AMDA)
  - Clinical Practice Guidelines: Falls & Fall Risk (Revised 2011)
- American Geriatrics Society (AGS)
  - Clinical Practice Guidelines: Prevention of Falls in Older Persons (Rev. 2010)
- Agency for Healthcare Research & Quality (AHRQ)
1. An important predictor of future falls
2. Ask the RESIDENT about the fall

History of Falls

1. Did you have a recent change in medications?
2. What do you think caused you to fall?
3. What were you doing before the fall?
4. How were you feeling before the fall?
5. Were you injured due to the fall?
6. Did you seek treatment?

Another Kind of Resident Assessment

1. Pain
2. New cough
3. “Color” change
4. Posture change
5. Change in routines
6. Off patterns or habits
7. Less visible in the community
8. Hospitalization / physician visit: check for changes in meds

Clues & Cues

WHO? WHY?

Early Identification

Early Response

Assessing the Environment: Internal

1. Lighting:
2. Walking:
3. Equipment:
4. Furnishings:
5. Monitoring Systems:
6. Risks in specific spaces:

Assessing the Environment: External

1. Patios
2. Vehicles
3. Sidewalks
4. Parking lot
5. Grassy areas
6. Weather-related
7. Seating and benches

Environmental Assessments

What do you see?

Keeping Your Fall Prevention Program Successful

1. GIVEN: Patient safety is an ORGANIZATIONAL PRIORITY
2. Two fundamental, consistent Falls Prevention messages:
   a. EVERY patient is at risk for falls
   b. EVERY employee has a role
3. Easy-to-understand data that drives unit level change
4. Ongoing assessment of plan effectiveness
5. Proper support equipment and resources
6. Simplified and standardized approach
7. Designated resources for managers
8. Staff education and training
RCCC Health and Rehabilitation: Dining Affects Falls

**ISSUE:** Increasing number of resident falls

**DATA:**
1. Significant number of falls at meal times
2. Low participation in congregate dining

**ANALYSIS and FINDINGS:**
1. Meal time
   a. Social Diner Served First
   b. Assisted Dining Served Last
2. Staff location at time of falls
   a. Staff was charting
   b. Call lights not answered
   c. Staff not available to assist
3. Negative staff and resident perceptions
   a. RESIDENTS: Meal served sooner in resident rooms
   b. STAFF: "Meal-to-resident" easier than "resident-to-meal"
**RCCC Health and Rehabilitation: Dining Affects Falls**

**DESIRED OUTCOMES:**
1. Increase dining participation to REDUCE:
   a. Falls
   b. Weight loss
   c. Food Complaints
   d. Behaviors/Increase socialization
   e. Pressure ulcers/ Increase movement
2. Increase the number of residents eating in dining room

**INTERVENTIONS:**
1. Mandated change for chart times
2. Re-education of staff & resident perception

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**Case Study: Mr. B**

**INCIDENT:** 84-year-old NH resident. Recently tripped and fell on a step...did not see the step, “my vision seems to be growing fuzzier.” Referred to optometrist to confirm eyeglass prescription for distance vision. The optometrist diagnosed macular degeneration.

**INTERVENTIONS:**
1. Given instructions re/ walking
2. Staff supervises Mr B when negotiating steps
3. Staff took measures to provide a safe environment
4. Checked room lighting and added a light by his bed
5. Encouraged to call for help when lacking confidence
6. Walker positioned by the bedside at night (self-toilets)

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**Sustaining Quality: Reducing Fall Risk in Senior Living Communities**

**Falls Session Agenda**

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**What is important to prevent falls?**

- Exercise
- Daily “contracting” with residents
- Mitigation
- Review/reduce medications
- Alert systems
- Remove obstacles
- Track/Share trends
- Low beds w/o rails

**ASSUMPTION:** You can’t prevent falls.

**REBUTTAL:** Falls prevention can be effective.

**EXAMPLES:** Important falls prevention elements?

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**Silverado Average Percentage of Falls Resulting in Injury 1999 – (Nov) 2007**

- 27%
- 22%
- 17%
- 12%
- 7.9%
- 5.6%
- 7.2%
- 5.7%
- 5.3%
- 0%
- 5%
- 10%
- 15%
- 20%
- 25%
- 30%

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**HELP, I’m Falling Into Financial Burden**

[Graph showing trends over years from 1999 to 2007]
“Daily Contracting” with Residents
SAFE from FALLS Toolkit

Resident and Family Engagement

1. Verbal “contracting” by each shift’s care giver:
   i.e. “We don’t want you to fall, Mr. Smith. We’re a Team, right? Will you promise to call me for some help before you get up?”

2. Resident and Family Education and Involvement:
   i.e. “You know Mom just had a medication change. If you notice anything different, please let us know.”

Other things that Staff could remind a Resident of?
1. Ask for help! It is OK.
2. Book … glasses … water … etc.
3. Wear your glasses / hearing aids
4. It’s OK to pause before you stand up.
5. Wear your shoes / slippers / non-skid socks
6. Keep your walker/cane/WC within reach and use it
7. Use the handrails in the bathroom and hallways
8. Make sure your pathway is clear
9. Tell us about any spills

“Daily Contracting” with Residents “Family Tips”

Sample tips:
1. Before you go home, please make sure (glasses, water, call light, over bed table, phone, Kleenex, etc.) are within reach.
2. Please notify staff / us before leaving if you notice confusion or disorientation in your Dad.
3. Please remind Mom to ask for help when she gets up.

How can People “HELP” to prevent falls?

RESIDENTS:
1. PARTICIPATE IN their Quality of Care
2. SEEK and ENGAGE IN their Quality of Life

STAFF and FAMILY:
1. IDENTIFY resident’s barriers to preventing falls
2. LEARN the changes a resident is willing to make
3. DEVELOPE an individual falls prevention program
4. VERIFY the residents’ understanding and retention
5. ENGAGE family members in falls prevention strategies
6. DEFINE “falls prevention” as staying independent longer
7. EMPOWER Residents and Families to discuss and decide

Staff dynamics

Authority v. Familiarity

Staff dynamics

CXO Long Term Care Summit, 2013, Las Vegas, NV

“Technology will be the key driver for Senior Living providers looking to reposition their communities in the future.”
“Between the health care that we now have, and the health care we could have, lies not just a gap, but a chasm.”

**Greg Alexander**
AP, MU Sinclair School of Nursing, 2013

**Recent Clinical Technology Advances**

- Tracking Wound Healing with Sensors
- Using Cell Phone Cameras to Measure Vital Signs
- Managing Continence in Nursing Homes

**The last national study of IT nursing homes was completed nearly a decade ago, and since then, NHs … have shifted the types of technologies being used.”**

**Greg Alexander**
AP, MU Sinclair School of Nursing, 2013

**Tracking Wound Healing with Sensors**

1. Sensor identifies an “event”
2. Event and observations transmitted to computer
3. Care giver notified thru technology
4. Care giver tends to resident needs & documents
5. Urinary continence and individual care planning

**Managing Continence in Nursing Homes**

- Care giver tends to resident needs & documents
- Urinary continence and individual care planning
- Sensor identifies an “event”
- Event and observations transmitted to computer

**Web-based tool was first to spot Ebola**

- They used a small, lightweight, wearable sensor that electronically monitors a patient's position and movements. Data collected by the sensor is communicated wirelessly to central monitoring stations or mobile devices so that caregivers can check on patient position and movement. The system provides alerts when necessary.
1. Tripping seniors on purpose to stop future falls

By LINDSEY TANNER; Aug. 28, 2014 1:22 AM EDT;
http://bigstory.ap.org/article/tripping-seniors-purpose-stop-future-falls

Data/Analysis Challenges -- Near-Miss Analysis

The Mishap **Reporting** Pyramid

- Severity
- Frequency

**St. Joseph Medical Center (II):**
- Enabled informal reporting of errors and **near-misses** among nursing staff
  - Holding safety briefings at shift changes (What did you see?)
  - Implementing "walk rounds" by hospital's executives
  - Instituting a telephone hotline to simplify reporting adverse drug events

- This resulted in a 91% drop in the rate of adverse drug events

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Data/Analysis Challenges -- Near-Miss Analysis

Near-Miss Analysis

**Near-Misses:**
"Trivial events in non-trivial systems should not go unremarked."

- Precursors of possible adverse events
- Employee choices make the difference between harm and no harm …
- So, how can we use it?
Mnemonics

"Every Good Boy Does Fine"
+ "FACE"
+ "ROYGBIV"

"Hand-off" Mnemonics

1. AIDET
2. ANTICipate
3. ASHICE
4. CUBAN
5. DeMIST
6. GRRRR
7. HANDOFFS
8. I PASS the BATON
9. Just Go NUTS
10. MIST13
11. PACE
12. PEDIATRIC
13. SBAR
14. I-SBAR
15. SBARR
16. SBAR-T

I-PASS the BATON

- Introduction
- Patient
- Assessment
- Situation
- Safety
- Background
- Actions
- Timing
- Ownership
- Next:

Just go NUTS

- Name
- Unusual or unique
- Tubes
- Safety

S-BAR Iterations *

S-BAR
- Situation
- Background
- Assessment
- Recommendation

I-SBAR
- Introduction
- Situation
- Background
- Assessment
- Recommendation

SBAR
- Situation
- Background
- Assessment
- Recommendation
- Thank residents (note: handoff done at bedside)

SBAR-T
- Situation
- Background
- Assessment
- Recommendation

SBAR-D
- Situation
- Background
- Assessment
- Recommendation
- Documentation

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I want to talk about “RCA”. WHY?

Element 5: Systematic Analysis and Systemic Action
The facility... uses a systematic approach:
1. To fully understand the problem, its causes, and implications of a change.
2. To determine... how identified problems may be caused or exacerbated by the way care and services are organized or delivered.
3. The facility will... demonstrate proficiency in the use of RCA... to prevent future events AND promote sustained improvement.

Element 11: Getting to the Root of the Problem
“Use the RCA process to look at the system rather than individuals when something breaks down.”

What is RCA?
A process to figure out:
1. What happened
2. Why did it happen
3. How to prevent it from happening again
4. OR, to prevent it from happening the 1st time

SIDEBAR: Ishikawa / Fishbone-ing

Change to Contracted Laundry Services – Asking “WHY”
Goal
Impacted
Effect
Cause / Effect
Cause / Effect
Effect / Cause
Solution / Intervention
Solution / Intervention
Solution / Intervention
(Issue is Defined)

Step 1. Issue / Problem

Step 1. Problem Outline

<table>
<thead>
<tr>
<th>What</th>
<th>Description</th>
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<tbody>
<tr>
<td>When</td>
<td>Date</td>
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<tr>
<td>Time</td>
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<tr>
<td>Where</td>
<td>Facility Name</td>
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<td>Location</td>
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<td>Process</td>
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Step 2. Goals

Sidebar: Examples of Quality Improvement Goal Categories and Goals

<table>
<thead>
<tr>
<th>Goal Categories</th>
<th>Specific Goals</th>
<th>Goal Categories</th>
<th>Specific Goals</th>
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<tbody>
<tr>
<td>Clinical</td>
<td>Mobility</td>
<td>Risk and Safety</td>
<td>Severity</td>
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<td>Pressure Ulcers</td>
<td>Patterns</td>
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<td></td>
<td>Pain Management</td>
<td>Frequency</td>
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<td>Infections (C. difficile)</td>
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<td>Medications (Antipsychotics)</td>
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<td>Resident Choice</td>
<td>Bathing</td>
<td>oska</td>
<td>F Tags</td>
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<td></td>
<td>Mobility</td>
<td>K Tags</td>
<td>Life Safety Code</td>
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<td>Discharge</td>
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<td>Organization / Infrastructure</td>
<td>Staff stability</td>
<td>Orientation</td>
<td>Family education</td>
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<td>Hospitalizations</td>
<td>Annual re-inservice</td>
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<td>Person-Centered Care</td>
<td>Mandatory inservices</td>
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<td>Consistent Assignments</td>
<td>Continuing Education</td>
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Step 3. Finding the Causes
RCA and Cause Mapping
("The Weed" and "Post-It Note Analysis")

Step 3a. Asking Why

Step 3b. Cause Mapping
"Post-It Note Analysis"
Step 4. Interventions / Solutions

**Fall Scenario: Mr. Regis, 77 y.o., active, alert, visually impaired due to macular degeneration, slipped and fell on ice getting out his daughter’s car, returning to building (fx elbow and shoulder)**

<table>
<thead>
<tr>
<th>Step 1. Problem Outline</th>
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<tr>
<td><strong>What</strong></td>
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<td><strong>When</strong></td>
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<td><strong>Time</strong></td>
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<td><strong>Different, unusual</strong></td>
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<td><strong>Where</strong></td>
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<td><strong>Facility Name</strong></td>
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<td><strong>Location</strong></td>
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<td><strong>Care / Work</strong></td>
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<td><strong>Process</strong></td>
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**Step 3a. Asking WHY**

- People, Hiring, HR
  - Newly contracted snow/ice removal
- P&P
  - Parking lot snow starts removal @ 3” & ongoing
  - Ice melt applied based on conditions
- Education
  - Clinical, Medical
  - Equipment
  - Broken weather radio

**Physical Plant (snow / ice)**

- Resident Fall
  - Resident not aware of unsafe conditions
  - Unseasonal storm
  - Thaw/ freeze prior day
  - New snow removal contractor

**Step 3b. Cause Mapping**

- Staff to inform or escort resident to car
- Communicate with family about calling or escorting Dad
- Replace broken weather radio
- Replace ice/ snow build-up
- Parental activation
- New snow removal contractor
- Unusual storm
- Thaw freeze prior day
- Resident not aware of unsafe conditions
- Ice and snow build-up
- Conditions not monitored (Maintenance offsite)
- Establish weekend policy
- Resident Fall
- Residents not aware of unsafe conditions
- Ice and snow build-up
- Unusual storm
- Thaw freeze prior day
- Resident Fall
- Residents not aware of unsafe conditions
- Ice and snow build-up
- Unusual storm
- Thaw freeze prior day
- Resident Fall
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- Unusual storm
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**Step 4. Interventions / Solutions**

<table>
<thead>
<tr>
<th>Owner</th>
<th>Cause</th>
<th>Intervention/Solution</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin</td>
<td>New snow removal contractor</td>
<td>Review contract with current vendor and replace if necessary</td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>Conditions not monitored (Maintenance offsite)</td>
<td>Replace weather radio</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>Conditions not monitored (Maintenance offsite)</td>
<td>Establish weekend policy</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Family drops resident off near front door</td>
<td>Communicate with family about calling or escorting</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Resident not aware of unsafe conditions</td>
<td>Staff to prepare to escort resident back in</td>
<td></td>
</tr>
</tbody>
</table>

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**Sustaining Quality: Reducing Fall Risk in Senior Living Communities**

1. Introduction
2. Claims, Costs, Considerations
3. Assessments and Interventions
4. People, Technology and Strategies
5. Quality Assessment Performance Improvement