J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

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Coding:	↓	Enter Codes in Boxes
0. None 1. One 2. Two or more	☐	A. **No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	B. **Injury (except major)** - as described in the CMS LTCF RAI User's Manual
	☐	C. **Major injury** - as described in the CMS LTCF RAI User's Manual

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.
- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.

DEFINITIONS

INJURY RELATED TO A FALL
Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

INJURY (EXCEPT MAJOR)
Includes*, but is not limited to,* skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

MAJOR INJURY
Includes*, but is not limited to, traumatic* bone fractures, joint dislocations*/ subluxations, internal organ injuries, amputations, spinal cord injuries*, head injuries, *and crush injuries*.

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Steps for Assessment

1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls.
4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury.
5. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record.
6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.

Coding Instructions for J1900

Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. **If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.**

Coding Instructions for J1900A, No Injury

- **Code 0, none:** if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900B, Injury (Except Major)

- **Code 0, none:** if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

- **Code 2, two or more:** if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Tips

- 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 Internet Quality Improvement and Evaluation System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall.
- *Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.*

Examples

1. A nursing note states that Resident K slipped out of their wheelchair onto the floor while at the dining room table. Before being assisted back into their chair, a range of motion assessment was completed that indicated no injury. A skin assessment conducted shortly after the fall also revealed no injury.

   Coding: J1900A would be **coded 1, one**.
   Rationale: Slipping to the floor is a fall. No injury was noted.

2. Nurse's notes describe a situation in which Resident Z went out with their family for dinner. When they returned, their child stated that while at the restaurant, Resident Z fell in the bathroom. No injury was noted when they returned from dinner.

   Coding: J1900A would be **coded 1, one**.
   Rationale: Falls during the nursing home stay, even if on outings, are captured here.

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3. A nurse's note describes a resident who, while being treated for pneumonia, climbed over their bedrails and fell to the floor. They had a cut over their left eye and some swelling on their arm. They were sent to the emergency room, where X-rays revealed no injury and neurological checks revealed no changes in mental status.

   Coding: J1900B would be **coded 1, one**.
   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

4. A resident fell, lacerated their head, and head CT scan indicated a subdural hematoma.

   Coding: J1900C would be **coded 1, one**.
   Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

5. Resident R fell on their right hip in the facility on the ARD of their Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Resident R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to iQIES. Three days later, Resident R complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment.

   Original Coding: J1900B, Injury (except major) is **coded 1, one** and J1900C, Major Injury is **coded 0, none**.
   Rationale: Resident R had a fall-related injury that caused them to complain of pain.
   Modification of Quarterly assessment: J1900B, Injury (except major) is **coded 0, none** and J1900C, Major Injury, is **coded 1, one**.
   Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to iQIES and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.

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6. *The therapist had Resident S, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the resident's balance. Despite providing contact guard assistance and use of safety mats, Resident S fell and landed on their left side. An X-ray was ordered due to pain and swelling of the left wrist which confirmed a distal radius fracture of the left wrist.*

   Coding: *J1800 would be* ***coded 1, yes*** *and J1900C would be* ***coded 1, one****.*
   Rationale: *Despite safety precautions in place, Resident S sustained a radius fracture as a result of a fall during a therapeutic intervention with physical therapy. This is a fall, as the clinician's interventions did not intercept the loss of balance, and the resident landed on the floor and sustained a fracture, which is a major injury.*

Differentiating from Traumatic vs. Pathological Fractures

7. *Resident A, who has osteoporosis, falls, resulting in a right hip fracture. The Emergency Department physician confirms that the fracture is a result of the resident's bone disease and not a result of the fall.*

   Coding: *J1800 would be* ***coded 1, yes*** *and J1900C would be* ***coded 0, none****.*
   Rationale: *The physician determined that the fracture was a pathological fracture due to osteoporosis. Because the fracture was determined to be pathological, it is not coded as a fall with major injury.*

8. *Resident L, who has osteoporosis, falls, resulting in a right hip fracture. The physician in the acute care hospital confirms that the fracture is a result of the resident's fall and not the resident's history of osteoporosis.*

   Coding: *J1800 would be* ***coded 1, yes*** *and J1900C would be* ***coded 1, one****.*
   Rationale: *Because the physician determined that the fracture was a result of the fall, it is a traumatic fracture and, therefore, is a fall with major injury.*