Below you will find F-tag language excerpted from the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev 66, 10-01-10).

F323

(Rev. 66, Issued: 10-01-10, Effective: 10-01-10 Implementation: 10-01-10)

§483.25(h) Accidents.

The facility must ensure that –
   (1) The resident environment remains as free from accident hazards as is possible; and
   (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

INTENT: 42 CFR 483.25(H) (1) AND (2) ACCIDENTS AND SUPERVISION
The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
   ▪ Identifying hazard(s) and risk(s);
   ▪ Evaluating and analyzing hazard(s) and risk(s);
   ▪ Implementing interventions to reduce hazard(s) and risk(s); and
   ▪ Monitoring for effectiveness and modifying interventions when necessary.

DEFINITIONS
Definitions are provided to clarify terms related to providing supervision and other interventions to prevent accidents.
   ▪ “Accident” refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. This does not include adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction).
     ▪ “Avoidable Accident” means that an accident occurred because the facility failed to:
       ▪ Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or
       ▪ Evaluate/analyze the hazards and risks; and/or
       ▪ Implement interventions, including adequate supervision, consistent with a resident’s needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or
Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.

“Unavoidable Accident” means that an accident occurred despite facility efforts to:

- Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and
- Evaluate/analyze the hazards and risks; and
- Implement interventions, including adequate supervision, consistent with the resident’s needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and
- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.

“Assistance Device” or “Assistive Device” refers to any item (e.g., fixtures such as handrails, grab bars, and devices/equipment such as transfer lifts, canes, and wheelchairs, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident’s function and/or safety.

**NOTE:** The currently accepted nomenclature refers to “assistive devices.” Although the term “assistance devices” is used in the regulation, the Guidance provided in this document will refer to “assistive devices.”

- “Environment” refers to the resident environment. (See definition for resident environment.)
- “Fall” refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.
- “Hazards” refer to elements of the resident environment that have the potential to cause injury or illness.
  - “Hazards over which the facility has control” are those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness.
  - “Free of accident hazards as is possible” refers to being free of accident hazards over which the facility has control.
- “Resident environment” includes the physical surroundings to which the resident has access (e.g., room, unit, common use areas, and facility grounds, etc.).
“Risk” refers to any external factor or characteristic of an individual resident that influences the likelihood of an accident.

“Supervision/Adequate Supervision” refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident’s assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

OVERVIEW
Numerous and varied accident hazards exist in everyday life. Not all accidents are avoidable. The frailty of some residents increases their vulnerability to hazards in the resident environment and can result in life threatening injuries. It is important that all facility staff understand the facility’s responsibility, as well as their own, to ensure the safest environment possible for residents.

The facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting residents’ rights to privacy, dignity and self determination, and their right to make choices about significant aspects of their life in the facility.

For various reasons, residents are exposed to some potential for harm. Although hazards should not be ignored, there are varying degrees of potential for harm. It is reasonable to accept some risks as a trade off for the potential benefits, such as maintaining dignity, self-determination, and control over one’s daily life. The facility’s challenge is to balance protecting the resident’s right to make choices and the facility’s responsibility to comply with all regulations.

The responsibility to respect a resident’s choices is balanced by considering the potential impact of these choices on other individuals and on the facility’s obligation to protect the residents from harm. The facility has a responsibility to educate a resident, family, and staff regarding significant risks related to a resident’s choices. Incorporating a resident’s choices into the plan of care can help the facility balance interventions to reduce the risk of an accident, while honoring the resident’s autonomy.

Consent by resident or responsible party alone does not relieve the provider of its responsibility to assure the health, safety, and welfare of its residents, including protecting them from avoidable accidents. While Federal regulations affirm the resident’s right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate, or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. The regulations hold the facility ultimately accountable for the resident’s care and safety. Verbal consent
or signed consent forms do not eliminate a facility’s responsibility to protect a resident from an avoidable accident.

An effective way for the facility to avoid accidents is to commit to safety and implement systems that address resident risk and environmental hazards to minimize the likelihood of accidents.² ³ A facility with a commitment to safety:

- Acknowledges the high-risk nature of its population and setting;
- Develops a reporting system that does not place blame on the staff member for reporting resident risks and environmental hazards;
- Involves all staff in helping identify solutions to ensure a safe resident environment;
- Directs resources to address safety concerns; and
- Demonstrates a commitment to safety at all levels of the organization.

**A SYSTEMS APPROACH**

Establishing and utilizing a systematic approach to resident safety helps facilities comply with the regulations at 42 CFR §483.25(h)(1) and (2). Processes in a facility’s system approach may include:

- Identification of hazards, including inadequate supervision, and a resident’s risks of potentially avoidable accidents in the resident environment;
- Evaluation and analysis of hazards and risks;
- Implementation of interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment; and
- Monitoring for effectiveness and modification of interventions when necessary.

A key element of a systematic approach is the consistent application of a process to consistently address identified hazards and/or risks. Risks may pertain to individual residents, groups of residents, or the entire facility. Hazards may include, but are not limited to, aspects of the physical plant, equipment, and devices that are defective or are not used properly (per manufacturer’s specifications), are disabled/removed, or are not individually adapted or fitted to the resident’s needs. An effective system not only identifies environmental hazards and the resident’s risk for an avoidable accident, but also the resident’s need for supervision.

Identifying and addressing risks, including the potential for accidents, includes consideration of the environment, the resident’s risk factors, and the need for supervision, care, and assistive devices. This will allow the facility to communicate information about observed hazards, identify resident-specific information, develop and implement an individualized plan of care to address each resident’s needs and goals, and to monitor the results of the planned interventions. The plan of care should strive to balance the resident’s wishes with the potential impact on other residents.
A systematic approach allows the facility to adjust its responses depending on the urgency of the situation and the hazards identified. The system includes a means for communicating the observations of hazards and the recording of resident specific information. Risks identified by the facility can pertain to individual residents or groups of residents. The facility-centered approach addresses risks for groups of residents; whereas, the resident-directed approach addresses risks for the individual residents.

**Identification of Hazards and Risks**

Identification of hazards and risks is the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. Various sources provide information about hazards and risks in the resident environment. These sources may include, but are not limited to, quality assurance activities, environmental rounds, MDS/CAAs data, medical history and physical exam, and individual observation. This information is to be documented and communicated across all disciplines.

**Evaluation and Analysis**

Evaluation and analysis is the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc.

Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. Evaluations also look at trends such as time of day, location, etc.

**Implementation of Interventions**

Implementation refers to using specific interventions to try to reduce a resident’s risks from hazards in the environment. The process includes: Communicating the interventions to all relevant staff, assigning responsibility, providing training as needed, documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident), and ensuring that the interventions are put into action.

Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based...
practice. Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully.

Facility-based interventions may include, but are not limited to, educating staff, repairing the device/equipment, and developing or revising policies and procedures. Resident-directed approaches may include implementing specific interventions as part of the plan of care, supervising staff and residents, etc. Facility records document the implementation of these interventions.

**Monitoring and Modification**

Monitoring is the process of evaluating the effectiveness of interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks.

Monitoring and modification processes include:

1. Ensuring that interventions are implemented correctly and consistently;
2. Evaluating the effectiveness of interventions;
3. Modifying or replacing interventions as needed and

An example of facility-specific modification is additional training of staff when equipment has been upgraded. An example of a resident-specific modification is revising the plan of care to reflect the resident’s current condition and risk factors that may have changed since the previous assessment.

**SUPERVISION**

Supervision is an intervention and a means of mitigating accident risk. Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident’s assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Tools or items such as personal alarms can help to monitor a resident’s activities, but do not eliminate the need for adequate supervision.

The resident environment may contain temporary hazards (e.g., construction, painting, housekeeping activities, etc.) that warrant additional supervision or alternative measures such as barriers to prevent access to affected areas of the resident environment.

Adequate supervision to prevent accidents is enhanced when the facility:

- Accurately assesses a resident and/or the resident environment to determine whether supervision to avoid an accident is necessary; and/or
- Determines that supervision of the resident was necessary and provides supervision based on the individual resident’s assessed needs and the risks identified in the environment.

**Resident Smoking**

Some facilities permit residents to smoke tobacco products. In these facilities, assessment of the resident’s capabilities and deficits determines whether or not supervision is required. If the facility identifies that the resident needs supervision for smoking, the facility includes this information in the resident’s plan of care, and reviews and revises the plan periodically as needed.

The facility may designate certain areas for resident smoking. The facility must ensure precautions are taken for the resident’s individual safety, as well as the safety of others in the facility. Such precautions may include smoking only in designated areas, supervising residents whose assessment and plans of care indicate a need for supervised smoking, and limiting the accessibility of matches and lighters by residents who need supervision when smoking. Smoking by residents when oxygen is in use is prohibited, and any smoking by others near flammable substances is also problematic. Additional measures may include informing all visitors of smoking policies and hazards.

Guidance concerning resident smoking regulations can be found in NFPA 101, the Life Safety Code at 19.7.4, Smoking, including requirements for signage, prohibiting smoking by residents classified as not responsible, and disposal of smoking materials. Refer to the guidance at 42 CFR 483.15(b)(3) [F242] for information about facilities that desire to be smoke-free.

**Resident-to-Resident Altercations**

**NOTE:** An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse under the guidance for 42 CFR §483.13(b) at F223. “Willful” means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. However, there are instances when a resident’s willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under this tag, F323.

It is important that a facility take reasonable precautions, including providing adequate supervision, when the risk of resident-to-resident altercation is identified, or should have been identified. Certain situations or conditions may increase the potential for such altercations, including, but not limited to:
• A history of aggressive behaviors including striking out, verbal outbursts, or negative interactions with other resident(s); and/or
• Behavior that tends to disrupt or annoy others such as constant verbalization (e.g., crying, yelling, calling out for help), making negative remarks, restlessness, repetitive behaviors, taking items that do not belong to them, going into others’ rooms, drawers, or closets, and undressing in inappropriate areas. Although these behaviors may not be aggressive in nature, they may precipitate a negative response from others, resulting in verbal, physical, and/or emotional harm.

The facility is responsible for identifying residents who have a history of disruptive or intrusive interactions, or who exhibit other behaviors that make them more likely to be involved in an altercation. The facility should identify the factors (e.g., illness, environment, etc.) that increase the risks associated with individual residents, including those (e.g., disease, environment) that could trigger an altercation. The care planning team reviews the assessment along with the resident and/or his/her representative, in order to identify interventions to try to prevent altercations.

The interventions listed below include supervision and other actions that could address potential or actual negative interactions:
• Providing safe supervised areas for unrestricted movement;
• Eliminating or reducing underlying causes of distressed behavior such as boredom and pain;
• Monitoring environmental influences such as temperatures, lighting, and noise levels;
• Evaluating staffing assignments to ensure consistent staff who are more familiar with the resident and who thus may be able to identify changes in a resident’s condition and behavior;
• Evaluating staffing levels to ensure adequate supervision (if it is adequate, it is meeting the resident’s needs); and
• Ongoing staff training and supervision, including how to approach a resident who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms.

RESIDENT RISKS AND ENVIRONMENTAL HAZARDS
This section discusses common, but not all, potential hazards found in the resident environment.

NOTE: The information included in the following sections is based on current standards of practice or “best practice” models as described in the industry literature.
The physical plant, devices, and equipment described in this section may not be hazards by themselves. But they can become hazardous when a vulnerable resident interacts with them. Some temporary hazards in the resident environment can affect most residents who have access to them (e.g., construction, painting, and housekeeping activities). Other situations may be hazardous only for certain individuals (e.g., accessible smoking materials).

In order to be considered hazardous, an element of the resident environment must be accessible to a vulnerable resident. Resident vulnerability is based on risk factors including the individual resident’s functional status, medical condition, cognitive abilities, mood, and health treatments (e.g., medications). Resident vulnerability to hazards may change over time. Ongoing assessment helps identify when elements in the environment pose hazards to a particular resident.

Certain sharp items, such as scissors, kitchen utensils, knitting needles, or other items, may be appropriate for many residents but hazardous for others with cognitive impairments. Handrails, assistive devices, and any surface that a resident may come in contact with may cause injury, if the surface is not in good condition and free from sharp edges or other hazards.

Improper actions or omissions by staff can create hazards in the physical plant (e.g., building and grounds), environment, and/or with devices and equipment. Examples of such hazards might include fire doors that have been propped open, disabled locks or latches, nonfunctioning alarms, buckled or badly torn carpets, cords on floors, irregular walking surfaces, improper storage and access to toxic chemicals, exposure to unsafe heating unit surfaces, and unsafe water temperatures. Other potential hazards may include furniture that is not appropriate for a resident (e.g., chairs or beds that are too low or unstable as to present a fall hazard) and lighting that is either inadequate or so intense as to create glare. Devices for resident care, such as pumps, ventilators, and assistive devices, may be hazardous when they are defective, disabled, or improperly used (i.e., used in a manner that is not per manufacturer’s recommendations or current standards of practice).

Resident Vulnerabilities
Falls and unsafe wandering/elopement are of particular concern. The following section reviews these issues along with some common potential hazards.

Falls - The MDS defines a fall as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would
have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.1

Some factors that may result in resident falls include (but are not limited to) environmental hazards, underlying medical conditions, medication side effects, and other factors (e.g., lower extremity weakness, balance disorders, poor grip strength, functional and cognitive impairment, visual deficits, etc.).

Older persons have both a high incidence of falls and a high susceptibility to injury.4 Falls can have psychological and social consequences, including the loss of self-confidence to try to ambulate. Evaluation of the causal factors leading to a resident fall helps support relevant and consistent interventions to try to prevent future occurrences. Proper actions following a fall include:

- Ascertaining if there were injuries, and providing treatment as necessary;
- Determining what may have caused or contributed to the fall;
- Addressing the factors for the fall; and
- Revising the resident’s plan of care and/or facility practices, as needed, to reduce the likelihood of another fall.

NOTE: A fall by a resident does not necessarily indicate a deficient practice because not every fall can be avoided.

Unsafe Wandering or Elopement - Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the facility aimlessly may indicate that the resident is frustrated, anxious, bored, hungry, or depressed. Unsafe wandering and elopement can be associated with falls and related injuries.5

Unsafe wandering may occur when the resident at risk enters an area that is physically hazardous or that contains potential safety hazards (e.g., chemicals, tools, and equipment, etc.). Entering into another resident’s room may lead to an altercation or contact with hazardous items.5

While alarms can help to monitor a resident’s activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.
Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility’s disaster and emergency preparedness plan should include a plan to locate a missing resident.†

**Physical Plant Hazards**
Supervision and/or containment of hazards are needed to protect residents from harm caused by environmental hazards. Examples of such hazards can range from common chemical cleaning materials to those caused by adverse water temperatures or improper use of electrical devices.

**Chemicals and Toxins**: Various materials in the resident environment can pose a potential hazard to residents. Hazardous materials can be found in the form of solids, liquids, gases, mists, dusts, fumes, and vapors. The routes of exposure for toxic materials may include inhalation, absorption, or ingestion.

For a material to pose a safety hazard to a resident, it must be toxic, caustic, or allergenic; accessible and available in a sufficient amount to cause harm. Toxic materials that may be present in the resident environment are unlikely to pose a hazard unless residents have access or are exposed to them. Some materials that would be considered harmless when used as designed could pose a hazard to a resident who accidentally ingests or makes contact with them.

Examples of materials that may pose a hazard to a resident include (but are not limited to):
- Chemicals used by the facility staff in the course of their duties (e.g., housekeeping chemicals) and chemicals or other materials brought into the resident environment by staff, other residents, or visitors;
- Drugs and therapeutic agents;
- Plants and other “natural” materials found in the resident environment or in the outdoor environment (e.g., poison ivy).

One source of information concerning the hazards of a material that a facility may obtain is its Material Safety Data Sheet (MSDS). ⁶ The Occupational Safety and Health
Administration (OSHA) requires employers to have a MSDS available for all hazardous materials that staff use while performing their duties. MSDSs are available on-line for numerous chemicals and non-toxic materials, and should be reviewed carefully to determine if the material is toxic and poses a hazard. Poison control centers are another source of information for potential hazards, including non-chemical hazards such as plants.

**NOTE:** Toxicological profiles for a limited number of hazardous materials are accessible on the Agency for Toxic Substances & Disease Registry Web site.

**Water Temperature** - Water may reach hazardous temperatures in hand sinks, showers, and tubs. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate.

The degree of injury depends on factors including the water temperature, the amount of skin exposed, and the duration of exposure. Some States have regulations regarding allowable maximum water temperature. Table 1 illustrates damage to skin in relation to the temperature of the water and the length of time of exposure.

<table>
<thead>
<tr>
<th>Water Temperature</th>
<th>Time Required for a 3rd Degree Burn to Occur</th>
</tr>
</thead>
<tbody>
<tr>
<td>155°F 68°C</td>
<td>1 sec</td>
</tr>
<tr>
<td>148°F 64°C</td>
<td>2 sec</td>
</tr>
<tr>
<td>140°F 60°C</td>
<td>5 sec</td>
</tr>
<tr>
<td>133°F 56°C</td>
<td>15 sec</td>
</tr>
<tr>
<td>127°F 52°C</td>
<td>1 min</td>
</tr>
<tr>
<td>124°F 51°C</td>
<td>3 min</td>
</tr>
<tr>
<td>120°F 48°C</td>
<td>5 min</td>
</tr>
<tr>
<td>100°F 37°C</td>
<td>Safe Temperatures for Bathing (see Note)</td>
</tr>
</tbody>
</table>

**NOTE:** Burns can occur even at water temperatures below those identified in the table, depending on an individual’s condition and the length of exposure.

Based upon the time of the exposure and the temperature of the water, the severity of the harm to the skin is identified by the degree of burn, as follows.
- First-degree burns involve the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling.
- Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin.
- Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black.

**Electrical Safety** - Any electrical device, whether or not it needs to be plugged into an electric outlet, can become hazardous to the residents through improper use or improper maintenance. Electrical equipment such as electrical cords can become tripping hazards. Halogen lamps or heat lamps can cause burns or fires if not properly installed away from combustibles in the resident environment. The Life Safety Code prohibits the use of portable electrical space heaters in resident areas.

Extension cords should not be used to take the place of adequate wiring in a facility. If extension cords are used, the cords should be properly secured and not be placed overhead, under carpets or rugs, or anywhere that the cord can cause trips, falls, or overheat. Extension cords should be connected to only one device to prevent overloading of the circuit. The cord itself should be of a size and type for the expected electrical load and made of material that will not fray or cut easily. Electrical cords including extension cords should have proper grounding if required and should not have any grounding devices removed or not used if required.

Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor, and printer. Power strips are not designed to be used with medical devices in patient care areas. Precautions needed if power strips are used include: installing internal ground fault and over-current protection devices; preventing cords from becoming tripping hazards; and using power strips that are adequate for the number and types of devices used. Overload on any circuit can potentially cause overheating and fire. The use of ground fault circuit interruption (GFCIs) may be required in locations near water sources to prevent electrocution of staff or residents.

The proper use of electric blankets and heating pads is essential to avoid thermal injuries. These items should not be tucked in or squeezed. Constriction can cause the internal wires to break. A resident should not go to sleep with an electric blanket or heating pad turned on. Manufacturer’s instructions for use should be followed closely. Injuries and deaths
have been related to burns and fires related to the use of heating pads. Most deaths are attributable to heating pads that generated fires, but most injuries are burns from prolonged use or inappropriate temperature setting. Prolonged use on one area of the body can cause a severe burn, even when the heating pad is at a low temperature setting.\(^\text{12}\)

**Lighting** - The risk of an accident increases when there is insufficient light or too much light, which often results in glare. Vision among older persons varies widely; therefore, no single level of illumination can ensure safety for all residents. The proper amount of light depends on the resident’s visual needs and the task he/she is performing.

An older person typically needs more light to see. However, a resident with cataracts or glaucoma may be overly sensitive to bright light, and excessive lighting could make it more difficult to see clearly and thereby increase his/her fall risk.\(^\text{13}\) Creating transitional zones between light and dark spaces helps to improve sight recovery and enable safer mobility. Providing extra visual cues that clearly define needed items or spaces in areas with limited or variable light can help to enable safe performance of tasks (e.g., turning on a light). Providing supplemental light near beds for patients who are mobile may assist in safe mobility at night.\(^\text{14}\)

**NOTE:** Refer to guidance for 42 CFR 483.15(h)(5) [F256] for lighting issues related to Quality of Life.

**Assistive Devices/Equipment Hazards**
Assistive devices also can help to prevent accidents. Assistive devices and equipment can help residents move with increased independence, transfer with greater comfort, and feel physically more secure. However, there are risks associated with the use of such devices and equipment, and these risks need to be balanced with the benefits gained from their use. Training of staff, residents, family members and volunteers on the proper use of assistive devices/equipment is crucial to prevent accidents. It is also important to communicate clearly the approaches identified in the care plan to all staff, including temporary staff. It is important to train staff regarding resident assessment, safe transfer techniques, and the proper use of mechanical lifts including device weight limitations.

**NOTE:** The Safe Medical Devices Act of 1990 (SMDA) requires hospitals, nursing homes, and other user facilities to report deaths, serious illnesses, and injuries associated with the use of medical devices to manufacturers and the Food and Drug Administration.

**Assistive Devices for Mobility** - Mobility devices include all types of assistive devices, such as, but not limited to, canes, standard and rolling walkers, manual or non-powered
wheelchairs, and powered wheelchairs. Three primary factors that may be associated with an increased accident risk related to the use of assistive devices include:

1. **Resident Condition.** Lower extremity weakness, gait disturbances, decreased range of motion, and poor balance may affect some residents. These conditions combined with cognitive impairment can increase the accident risks of using mobility devices. Unsafe behavior, such as failure to lock wheelchair brakes and trying to stand or transfer from a wheelchair unsafely, can result in falls and related injuries;

2. **Personal Fit and Device Condition.** Devices can pose a hazard if not fitted and/or maintained properly. Personal fit, or how well the assistive device meets the individual needs of the resident, may influence the likelihood of an avoidable accident; and

3. **Staff Practices.** Mobility devices that a resident cannot readily reach may create a hazardous situation. Unsafe transfer technique used by staff may result in an accident. Inadequate supervision by staff of a resident during the initial trial period of assistive device use or after a change in the resident’s functional status can increase the risk of falls and/or injury. Additionally, staff needs to ensure assistive devices properly fit the resident and the resident has received proper training in the use of the assistive device.

**Assistive Devices for Transfer** - Mechanical assistive devices for transfer include, but are not limited to, portable total body lifts, sit-to-stand devices, and transfer or gait belts. The resident assessment helps to determine the resident’s degree of mobility and physical impairment and the proper transfer method; for example, whether one or more caregivers or a mechanical device is needed for a safe transfer. Residents who become frightened during transfer in a mechanical lift may exhibit resistance movements that can result in avoidable accidents. Communicating with the resident and addressing the resident’s fear may reduce the risk.

Factors that may influence a resident’s risk of accident during transfer include staff availability, resident abilities, and staff training. The resident’s ability to communicate and identify physical limitations or to aid in the transfer will help determine the need for an assistive device, such as a mechanical lift.

**Devices Associated with Entrapment Risks** - Devices can be therapeutic and beneficial; however, devices are not necessarily risk free so it is important to weigh the relative risks and benefits of using certain devices. For example, while physical restraints may be used to treat a resident’s medical symptom, the devices may create a risk for entrapment. Physical restraints are defined in the SOM at F221 as any manual method,
physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily and that restricts freedom of movement or normal access to one’s body.

In 1992, the Food and Drug Administration (FDA) issued a Safety Alert entitled “Potential Hazards with Restraint Devices”. Serious injuries, as well as death, have been reported as a result of using physical restraints. Some physical restraints carry a risk of severe injury, strangulation, and asphyxiation. Restrained residents may be injured or die when they try to remove restraints, to ambulate while restrained, or due to an improperly fitted or used device.

Regardless of the purpose for use, bed rails (also referred to as “side rails,” “bed side rails,” and “safety rails”) and other bed accessories (e.g., transfer bar, bed enclosures), while assisting with transfer and positioning, can increase resident safety risk. Bed rails include rails of various sizes (e.g., full length rails, half rails, quarter rails) that may be positioned in various locations on the bed. In 1995, the FDA issued a Safety Alert entitled “Entrapment Hazards with Hospital Bed Side Rails.” Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. that may cause them to move about the bed or try to exit from the bed. The timeliness of toileting, appropriateness of positioning, and other care-related activities can contribute to the risk of entrapment.

Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Technical issues, such as the proper sizing of mattresses, fit and integrity of bed rails or other design elements (e.g., wide spaces between bars in the bed rails) can also affect the risk of resident entrapment.

The use of a specialty air-filled mattress or a therapeutic air-filled bed may also present an entrapment risk that is different from rail entrapment with a regular mattress. The high compressibility of an air-filled mattress compared to a regular conventional mattress requires appropriate precautions when used for a resident at risk for entrapment. An air-filled mattress compresses on the side to which a person moves, thus raising the center of the mattress and lowering the side. This may make it easier for a resident to slide off the mattress or against the rail. Mattress compression widens the space between the mattress and rail. When a resident is between the mattress and rail, the mattress can re-expand and press the chest, neck, or head against the rail. While using air therapy to prevent and treat pressure ulcers, facilities should also take precautions to reduce the risk of entrapment. Precautions may include following manufacturer equipment alerts and increasing supervision.
NOTE: 42 CFR 483.13(a), F221, applies to the use of physical restraints. 42 CFR 483.25(h)(2), F323 applies to assistive devices that create hazards (e.g., devices that are defective; not used properly or according to manufacturer’s specifications; disabled or removed; not provided or do not meet the resident’s needs (poor fit or not adapted); and/or used without adequate supervision when required).

ENDNOTES


7 US Dept. of Labor, Occupational Safety and Health Standards, 29 CFR 1910.1200 (g)(1) and (2)


**NOTE:** References to non-CMS/HHS sources or sites on the Internet included above or later in this document are provided as a service and do not constitute or
The following Mandatory Task Form has questions pertaining to F323 and must be completed during every survey.

Environmental Observations (CMS-20061)

Observations

Review Stage I information. Why was this task triggered?

Resident Observation Questions:
- ☐ Bathing Safety Equipment
- ☐ Bedroom Privacy
- ☐ Comfortable Room Temperatures Maintained
- ☐ Functioning Call System
- ☐ Resident Care Equipment
- ☐ Ambulation, Transfer, Therapy Equipment (Resident Use)
- ☐ Clean Linens Available
- ☐ Comfortable Sound Levels Maintained
- ☐ Lighting Levels
- ☐ Room Accommodations
- ☐ Electric Cords and Outlets
- ☐ Pest Control
- ☐ Room Odors

Resident Interview Questions:
- ☐ Building and Environment (Resident Interview)

Family Interview Questions:
- ☐ Building and Environment (Family Interview)

Required Posted Information
- Are Medicare and Medicaid information prominently displayed?
- Are the names, addresses, and telephone numbers of advocacy groups and the state survey agency posted?
- Is a statement that the resident may file a complaint with the survey agency displayed?

6. Are handrails accessible, securely affixed to the walls, and free from splinters or jagged edges?
10. Are potentially hazardous chemicals or other poisons inaccessible to residents?
   □ Yes
   □ No

17. Are water temperatures within acceptable ranges?
   □ Yes
   □ No

18. Is there adequate safety equipment (e.g., grab bars, non-slip surface) in the common bathing areas?
   □ Yes
   □ No

If you answered “no” to any of these questions, you might be out of compliance with F-323.

Water Temperatures in Resident Rooms
Check water temperature in two resident rooms (on opposite sides of the hall) per unit/wing/pod.
   • Target resident rooms closest to hot water tanks/kitchen areas and resident rooms belonging to residents who use sinks/bathtubs/showers independently.
   • Water temperature at hand sinks or bathtubs should be taken using a thermometer, if there is concern that water is too hot and could potentially scald or harm residents.

20. Are water temperatures within acceptable ranges in the resident rooms?
   □ Yes
   □ No

If you answered “no” to this question, you might be out of compliance with F-323.
Stage II – General Critical Element Pathway (CMS-20072)

Use
Use this protocol for a sampled resident having a care issue not addressed in one of the specific Critical Element (CE) Pathways.

Examples of areas not addressed in other CEs include areas such as non-pressure related wound care (venous/arterial or neuropathic ulcers); bowel management problems including fecal impaction; and conditions such as diabetes mellitus and congestive heart failure. This general CE can also be used to review issues related to accidents and supervision, such as falls, fractures, elopements, and hazards related to the use of assistive devices.

Procedure
- Briefly review the assessment, care plan and orders to identify facility interventions and to guide observations to be made.
- Corroborate observations by interview and record review.

Observations (if the resident is still in the facility)
- Observe whether staff consistently implement the care plan over time and across various shifts. Staff are expected to assess and provide appropriate care from the day of admission.
- During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes.

Resident/Representative Interview
Interview the resident, family or responsible party to the degree possible to identify:
- The resident’s/representative’s involvement in the development of the care plan, goals, and if interventions reflect choices and preferences;
- The resident’s/representative’s awareness of care plan approaches;
- If treatment(s) was refused, whether counseling on alternatives, consequences, and/or other interventions were offered; and
- The resident’s/representative’s awareness of the current condition(s) or history of the condition(s) or diagnosis/diagnoses.

Staff Interviews
Interview staff on various shifts to determine:
- Knowledge of prevention and treatment, including facility-specific guidelines/protocols and specific interventions for the resident;
- Whether staff identified and implemented appropriate measures as related to specific conditions and/or diagnoses;
□ Whether nursing assistants: (1) know what, when, and to whom to report changes in condition; and (2) are aware of interventions needed to meet the resident’s needs; and
□ Whether the nurse monitors for the implementation of the care plan, and changes in condition.

Provision of Care and Services

Compliance with F323, Accidents and Supervision — For a resident who experienced falls, fractures, elopements, hazards related to the use of assistive devices, or other related concerns with accidents/accident hazards and supervision to prevent accidents, the facility is in compliance with this requirement, if staff have:

- Recognized and assessed factors placing the resident at risk, including specific conditions, causes and/or problems, needs and behaviors;
- Defined and implemented interventions in accordance with residents needs, goals, and recognized standards of practice;
- Monitored and evaluated the resident’s response to efforts and interventions; and
- Revised the approaches as appropriate.

If not, the facility did not provide care necessary to meet the needs of the resident: cite F323.

5. Based on observation, interviews, and record review, did the facility provide care necessary to meet the needs of the resident with the identified clinical diagnosis and/or condition?
   □ Yes
   □ No

If you answered “no,” you might be out of compliance with F-323.

Stage II – Critical Elements for the Use of Physical Restraints (CMS-20077)

Use
Use this protocol for:
   □ A sampled resident who has MDS data that indicates a physical restraint is used; or
   □ Surveyor observation of a device or practice that may be physically restraining the resident.

The goal of using this CE is to determine, for a resident the surveyor has determined to be restrained, whether the restraint is in compliance with the regulations. To be in compliance, the restraint:
Must be necessary to treat a medical symptom;
Must not be used to discipline a resident or for staff convenience in the absence of a medical symptom;
Must not be used because of family request in the absence of a medical symptom; and
Must be the least restrictive device possible, in use for the least amount of time per day possible; and the facility must have an active plan in place to decrease usage or for eventual removal of the restraint.

**NOTE:** Physical restraint includes all devices and practices used by the facility that restrict freedom of movement or normal access to one's body. This includes side rails as well as facility practices such as tucking in bed sheets so tightly that the resident is unable to leave the bed.

**NOTE:** Do not rely on facility documentation alone to determine whether the device or practice is a restraint. It is a surveyor's determination whether the device or practice is restraining the resident, despite facility documentation to the contrary. If facility records state that the device (or practice) is not a restraint, but your investigation finds otherwise, the device or practice is a restraint.

**NOTE:** If the device does not meet the definition of a physical restraint, discontinue completion of this CE.

**Procedure**
- Briefly review the assessment, care plan and orders to identify facility interventions and to guide observations to be made.
- Corroborate observations by interview and record review.

**Observations (if the resident is still in the facility)**
Observe whether staff consistently implement the care plan over time and across various shifts. Staff are expected to assess and provide appropriate care from the day of admission. During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes. Determine:
  - The type of restraint in place;
  - The resident's reaction to the restraint;
  - Whether the restraint is applied correctly;
  - The services that are provided to meet resident needs while the restraint is not in place; and
  - If the restraint affects position and body alignment, the resident is positioned appropriately.
NOTE: A resident may have a device in place that the facility has stated can be removed by the resident. For safety reasons, do not ask the resident to release the device unless there is facility staff supervision.

Resident/Representative Interview
Interview the resident, family or responsible party to the degree possible to identify:
- The resident's/representative's involvement in the development of the care plan, goals, and if interventions reflect choices and preferences;
- The resident's/representative's awareness of care plan approaches; and
- Whether counseling on alternatives, consequences, and/or other interventions were offered prior to, or in addition to physical restraint use.

Staff Interviews
Interview staff on various shifts to determine:
- Knowledge of specific interventions for the resident, including:
  - The restraint(s) being used (and when use was initiated);
  - How often and under what circumstances the restraint(s) is used;
  - When, and for how long, the restraint is released;
  - The potential risks of using the restraint;
  - How the resident is monitored when the restraint is in use; and
  - Interventions that are in place to minimize or eliminate the medical symptom or underlying problems causing the medical symptom.
- Knowledge of facility-specific guidelines/protocols; and
- Whether the nurse monitors for the implementation of the care plan, and the frequency of review and evaluation of changes in the effectiveness or resident response to the restraint.
- What the resident’s functional ability is such as bed mobility and ability to transfer between positions, to and from bed or chair, and to stand and toilet; and
- Any changes over the past year such as increased incontinence, decline in ADLs or ROM, increased confusion, agitation, and depression.

Concerns with Structure, Process, and/or Outcome Requirements Related to Process of Care
During the investigation, the surveyor may have identified concerns with related outcome, process and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present. Some examples of requirements that should be considered include the following (not all inclusive):
☐ **F323, Accidents** — Determine whether the restraint use has caused or is likely to cause a resident fall or other accident, either due to the resident’s response to the restraint or due to misapplication of the restraint by staff.

*If the surveyor determines that the facility is not in compliance with any of these related requirements, the appropriate F tag should be surveyor initiated.*