# Final Report 3-Year FL CMP Grant Project

## Reducing Alarm and Reducing Falls Years 1 and 2
## &
## Proactive Practices to Prevent Falls Year 3

## Awarded to Edu-Catering by the
## State of Florida, Agency for Health Care Administration


### Summary
A 3-year grant was awarded to Edu-Catering in 2019. The goal was to find 15 homes to participate each year, to learn simple, practical proactive practices to prevent falls. Simultaneously a goal was to replace bed and chair alarms with these better practices. Teams agreed to submit data pre- and post-project, participate in monthly educative webinars, in an every-other month coaching call and to implement practices learned.


### Personal Alarms No Longer Used
A good outcome of the first two years, also indicative of what happened nationally, was that nursing homes stopped using the personal alarms as much. You do still hear of some homes but not near as much. This affected this grant project so much so that a revised proposal had to be made to drop the requirement for a participating nursing home to be using alarms. This is a very good problem. From the start, many nursing home teams had interest in the project even if they no longer used alarms and they had to be turned away looking for teams still using alarms. So, years 1 and 2 had the replacing alarms component and most of those homes had no alarms or very few by the end of those years.

### Year 1 April 2019 – March 2020
The first year began April 2019 and did take place all twelve months up until March 2020 right when the COVID-19 pandemic hit.

Although the grant supported 15 homes, only ten signed up for year one. The state of Florida kindly supported another change to the grant whereby the allotted money was used by offering half of the homes a monthly coaching call. So, all ten took part in the monthly education on proactive practices to prevent falls, five had coaching calls every month and five had coaching calls every other month, and all implemented practices learned for the 12 months. It was also a focus at the time to learn the reasons to stop using alarms and then also learn the better practices that prevent falls.

### In six of these ten homes falls decreased.
These numbers represent total number of falls during the first month of the project and total number of falls during the last month of the project:

1. Courtney Springs **18 to 6**
2. Healthcare at Brentwood **21 to 14**
3. Regents Park **42 to 28**
4. Signature Chautauqua **37 to 16**
5. Signature Peninsula **23 to 16**
6. Sunset Lake **31 to 10**

Regarding the other four homes in the project: one home began with 8 and ended with 8 falls; two homes experienced an increased number of falls, and one home did get from 31 to 17 at one point but had 33 falls in the last month.

These teams overall shared that what they predominantly implemented was increased team involvement soliciting more ideas to prevent falls per individual person (resident).
Details regarding each home, each action plan for each month and fall data for each home is captured in the Annual Report Year 1 April 2019 – March 2020.

COVID-19 caused a pause in the project from April to August 2020.

**Year 2 August 2020 - July 2021**
Fifteen homes did sign up; fourteen were with one company; the fifteenth home did have to exit the project early on, however. By the end of the project corporate team members shared that many of the practices were now embedded in company policies and procedures.

These fourteen nursing home teams took part in monthly education on proactive practices to prevent falls, coaching calls every other month and implemented practices learned.

**In 8 of these 14 homes, the monthly fall average decreased.**

These numbers represent the 12-month average monthly falls pre-project (August 2019-July 2020) and post-project (August 2020-July 2021).

1. Marshall **26 to 18**
2. Orange Park **22 to 18**
3. San Jose **26 to 16**
4. Tallahassee **14 to 10**
5. Lake Mary **36 to 34**
6. Oaktree **10 to 8**
7. Pensacola **14 to 13**
8. Governor's Creek **13 to 12**

Regarding the remaining six homes: 2 homes' fall averages remained the same and 4 homes' averages increased. These teams were less able to implement practices as a result of being hit harder with COVID-19 and resulting staffing challenges.

These teams overall shared that they implemented increased team involvement with more individualized ideas to prevent falls, getting to know the details of residents' lives, purposefully discovering details during move-in from the resident and/or family, more individual care plans, anticipation of resident needs, particularly bathroom needs but also ensuring personal items area within reach to the person, and proactive checking in with residents by a much wider team (not just nursing) and more often.

**Education/Proactive Practices learned in Years 1 and 2 (emphasis on not using alarms):**

1. The Harms of Alarms
2. Alarms: The New Deficient Practice – the seven CMS regulations that could be cited
3. Increased Individualized Mobility by All
4. Anticipating Needs, particularly bathroom, by All
5. Proactively checking in with residents by All
6. Meaningful Individualized Engagement by All
7. Even More Proactive Practices to Reduce Falls
8. Individualized Care Plans to include better practices to Prevent Falls
9. Honoring Sleep and Open Dining
10. Highest Practicable Level of Well-being as required by CMS regulations
11. The Eden Alternative® 7 Domains of Well-being - now part of CMS requirements
12. End Results of Project and Lessons Learned per Team.

Details regarding each home, each action plan for each month and fall data for each home is captured in the Annual Report Year 2 August 2021 – July 2022.

**Year 3 August 2021-July 2022**

Fifteen homes signed up and remained the entire year which is to be commended even with it being the third year of working under pandemic conditions. Fourteen were with one company.

**Self-Assessment Added**

A Self-Assessment tally of Proactive Practices to Prevent Falls was developed for this 3rd year. There were 28 practices. This was added as both an educative tool, a benchmarking opportunity with another set of data to look at and see accomplishment with implementation of proactive practices that enhance fall reduction for residents.

**Education/Proactive Practices learned in Year 3:**

1. Fall Prevention Strategies and a Self-Assessment
2. Proactive Practice: Anticipating Needs, particularly bathroom
3. Proactive Practice: Proactively checking in with residents by ALL
4. Proactive Practice: Individualized Increased Movement by ALL
5. Proactive Practice: Meaningful Engagement by All
6. Lots of other Proactive Best Practices to Reduce Falls
7. Proactive Practices: Honoring Sleep/Natural Awakening, Open Dining Times
8. Highest Practicable Level of Well-being as required by CMS regulations
9. The Eden Alternative® 7 Domains of Well-being - now part of CMS regs
10. Individualizing Care Plans to include best practices and proactive practices
11. End Results of Project, Lessons Learned, Send Off – First Half of Homes
12. End Results of Project, Lessons Learned, Send Off – Second Half of Homes

**Of the 15 homes, 3 saw average number of falls decrease:**

1. Orchid Cove of Naples **11.25 to 8.83** (project contact/DON throughout the project).
2. Orchid Cove of Stuart slightly **20 to 18** (administrator throughout the project).
3. Orchid Cove of Venice **13.6 to 11.07** (administrator throughout the project).

Regarding the other 12 homes, averages increased. This was unfortunate to see and over and over again when asked, teams stated the difference was stable staff vs. unstable/agency staff. The world of long-term care saw turnover like never before with vaccination mandates and very difficult circumstances to work under. Turnover was within administration as well. Of the 15 homes, administrators turned over in 8 in this year.

**Regarding the Self-Assessment tally, although every home's tally increased, the most notable homes with improvement were:**

1. Anchor Care 0 to 22 proactive practices (administrator throughout the project).
2. Balanced 0 to 20 proactive practices (administrator throughout the project).
3. Orchid Cove of Venice 1 to 22 proactive practices (administrator throughout the project).

These teams overall shared that they too involved more team members, now seek more information, more details about individuals' lives both before they move in as well as after, offering more engagement and adult/dignified activities, getting outside more, using lavender more, honoring sleep and natural awakening more, teaching the 4Ps and an E to all team members, engaging all team members in their role to be able to prevent falls and sharing data more freely, creating normal home instead of institutional homelike facility. This year's teams also focused on preempting falls by recognizing falls will happen when someone is new, you can plan on it. Thus, they proactively tip off all team members to be aware of this and to orient the person to their room and parts of the building over and over also more

proactively ensuring room is how they want it and the exact same as last room when and if switching rooms.

Details regarding each home, each action plan for each month and fall data for each home is captured in the three annual reports attached.

**Lessons Learned: Three years of seeking to reduce falls**

No home saw falls decrease every month in this particular project sadly. This was probably to be expected but with living several years through a pandemic and loss of staff, having to use agency staff, this took a toll on total falls. It is true when you see a stable team work together and implement proactive practices, falls decrease. This was stated by many in the project month after month: if falls were increased you would hear well, we have 50% agency in the building; or if falls decreased, they would say we have stable staff again and/or we have really focused on these simple techniques and using them and reducing falls.

Some ideas for improvement are creating a packet of information to use for face-to-face team training/short huddles; monthly calls instead of every other month would keep the proactive practices on the forefront of teams' minds with so many things happening; and a new approach of *agreed-upon action plans* which are more prescribed rather than left wide open to experiment if ensuring these practices are implemented, falls reduce for people living in nursing homes.

In each year of the project there was this story: lavender lotion used with a person at night helped them to sleep better and… "she never fell again." Additionally there was this story each year to some degree: we learned him and his patterns and his interests and now he has a basketball hoop on the door of his room and hasn't fallen since or help him get outside to the pond like he always did and/or to the window to see the pond and to the aviary and he hasn't fallen since or we support her to care for the tortoise in the courtyard and she hasn't fallen since. Please see each year's reports for success stories such as these for each participating home. If such simple approaches can be learned and implemented and quality of life improved for people living in nursing homes, let's continue to teach them!

Thank you to the Florida Agency for Health Care Administration and CMS Region IV/Atlanta for approving and supporting this 3-year grant.

Submitted by Carmen Bowman, Edu-Catering, Project Coordinator

Replacing Alarms and Reducing Falls with Better Practices Project
Sponsored by Edu-Catering and the State of Florida, Agency for Health Care Administration

**Final Year 1 Report Apr. 2019 – Mar. 2020**

This report consists of the following required updates:
1. Summary of project participation
2. Resident outcome data
3. Nursing home team action plans
4. Webinar survey results
5. Project successes and failures

## 1. Summary of project participation

The entire project went well. No home dropped out, thankfully. All documents were submitted up until and other than the last month, March of 2020 with the advent of the COVID-19 pandemic. Not every home was as able to finish strong as they had hoped. In general, submission of webinar surveys/action plans after each webinar is not always smooth, it took some teams until the last of the month instead of the beginning of the month/right after the webinar which is the design of the project. The design was to give education on a topic at the end of one month devising a plan for the following month. For year two, we decided to try it a little differently by holding the webinar at the beginning of the month and ask for a plan for that same month. Also, will offer to ask the questions of the survey/action plan during the coaching call if it helps the team. It does not take much time, this will facilitate getting that information and may help the team to make decisions regarding ongoing action plans.

The original design was for 15 homes to be a part of the project; however, only 10 signed up in the short one month planned for advertising. As a result, giving two months lead time for advertising was planned for year two until the COVID-19 crisis created a pause in the project. Ideally two months will be given if possible, for getting the word out about the project and then for sure for year three of the project. The Florida Pioneer Network did ensure that every home in Florida heard of the project and will do so again when it is resumed.

Use of grant money was reallocated when 10 homes signed up rather than the planned for 15 to offer calls every month for five homes and thankfully five did sign up for monthly calls. The other five had every other month calls.

The ten participating Florida nursing homes were:
1) Courtenay Springs Village, Merritt Island
2) Healthcare at Brentwood, Lecanto
3) Regents Park, Boca Raton

4) River Valley Rehabilitation Center, Blountstown
5) Signature – The Courtyard, Marianna
6) Signature – Chautauqua Rehab, Defuniak Springs
7) Signature – Peninsula Care and Rehab, Tarpon Springs
8) Signature – Washington Rehab & Nursing, Chipley
9) Sunset Lake Health and Rehab Center, Venice
10) Ybor City Healthcare and Rehabilitation Center, Ybor City

Five homes had coaching calls every month:

1. Regent Park
2. Signature Peninsula
3. Courtenay Springs Village
4. Signature – The Courtyard
5. Ybor City

Five homes had coaching calls every other month:

1. Sunset Lake
2. River Valley
3. Signature Chautauqua
4. HC at Brentwood
5. Signature Washington

No significant differences stood out between the homes with every month calls compared to every other month calls.

**2. Resident outcome data AND 3. Nursing home team action plans**

| Courtenay Springs | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 21 | 15 | 10 | 8 | 8 | 6 | 6 | 6 | 5 | 5 | 4 | - |
| Residents with alarms | 21 | 15 | 10 | 8 | 8 | 6 | 6 | 6 | 5 | 5 | 4 | - |
| Falls | 18 | 13 | 8 | 8 | 10 | 10 | 12 | 10 | 15 | 10 | 6 | - |
| Fall w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | - | - |

Courtenay Springs Village Action Plans

Webinar 1 Action Plan: Interview staff as to whether residents call for assistance sometimes, always, or never on each shift. Increased time spent outdoors by residents to improve circadian rhythm. Promote restorative sleep. Increase hydration and snacks at 10 am, 2 and 8 pm. Increase evening activities. Fall monitor on 3-11 shift; one staff member hired for this position, need one person for 7-day coverage.

Webinar 2 Action Plan: Continue speaking with residents/families at care plan meetings and resident council about improving restorative sleep, how many times do they want to be woken up at night. Engage all staff to ask 4 basic needs questions: Pain, Personal Needs, Positioning, Personal items and Can I get you anything?" In late June, hired one 7a-7p restorative C.N.A. to assist with increased walking, helping residents to restroom before and after every meal, and encourage walk to dine.

Webinar 3 Action Plan: Increase restorative CNAs to help with helping people to the bathroom before and after all meals. Restorative CNAs to work with staff to increase participation in Walk to Dine. Involve all staff to come up with ideas to rename "units" and then involve residents to rename the "units" with a choice of three names.

Webinar 4 Action Plan: Individualize residents' preference for easy staff access. Post open dining services signage. Encourage residents/family members to work on engagement/A Few of my Favorite Things boxes with favorite items. Buddy system for new employees. Buddy system for residents, presently 3 residents engaging in meeting and befriending new residents.

Webinar 5 Action Plan: After Breakfast and Bathroom have an outdoor walking club with residents who walk first, then residents that use an assistive device and then both go to exercise class. And some residents who walk help other residents that use a wheelchair. Contact local shelters/animal volunteers to come so residents can interact with dogs. Hire a personal trainer.

Webinar 6 Action Plan: Personal trainer/activities assistant hired. Presently in training to become a certified Yoga instructor. All CNAs were given a restorative training class. The 4Ps pain, position, personal hygiene, personal preferences (including engagement) is now part of orientation with all staff.

Webinar 7 Action Plan: Corporate compliance officer is formulating a policy/procedure regarding pets. Personal trainer/Yoga instructor/activities assistant starts next week. Staff will be invited to practice Yoga with and to assist residents during class. Add 4 P/s and an E to the Guardian Angel duties performed by managers and ancillary staff.

Webinar 8 Action Plan: Guardian Angels to ask their residents/families about preferred sleep habits and acceptable staff interruptions for care. One of the questions will be "Do you want to be awoken'? Personal trainer/Yoga instructor resigned her position here. Activities director will look into the requirements/cost to become yoga certified. NHA will contact lab to change blood drawing time to 6 am. If the lab cannot accommodate us, we will pursue another lab contract.

Webinar 9 Action Plan: Lavender lotion in all shower rooms for use after showers (alternate available). Utilize lavender/alternate lotion in activity rooms during manicures, and manicurist will use in resident's rooms during manicures.

Webinar 10 Action Plan: Increase number of trips to movies, malls, social events.

Webinar 11 Action Plan: Home unable to complete due to COVID-19 crisis.

Webinar 12 Action Plan: Home unable to complete due to COVID-19 crisis.

Review interventions and statistics at the monthly QAPI meetings with medical director also discuss at monthly staff meetings and engage staff for suggestions and ongoing feedback.

Success stories: As part of a company Falls Collaborative, CSV was already implementing the following new practices: Increased time outdoors to improve circadian rhythm; Promote restorative sleep; Increase hydration and snacks; Increase evening activities; Fall monitors: have 7-day coverage. We learned from this that it seems the more practices a team does implement, the higher the chance for fewer falls. CSV was an early home to see falls decrease in the first three months. Also, their company's collaborative seemed to confirm the practices of this project as many were the same.

This team created what they ended up calling A Few of My Favorite Things boxes with meaningful engagement items for individual residents and posted individual preferences. They were a first team to simply ask residents if they want to be woken during the night or not. They got corporate clearance for animals during the project and came up with the creative idea to Bring your Dog to Work Day. They also give the tip that if a resident doesn't like lavender scent, try cucumber melon.

Their insurance company did a site visit and was very impressed with all CSV team has done to prevent falls. Also, this team offers to residents to order food "dawn to dusk" – giving great resident choice. Therapy team offers a laser beam gun set for shooting for movement and engagement. Residents love it, they were hunters, it is a familiar tool, and helps to improve balance and eye hand coordination. Activities team goes room to room every 30-60 minutes to offer residents things to do and create connection – and this was before COVID-19!

During a coaching call the director of nursing impressively said, "I don't simply want the quality measures to improve. I want to create a place filled with employees who care about quality of their own initiative constantly making quality improvements. New focus and measure."

Contact: Rosemarie Perri, RN, WCC, DON 1100 S. Courtenay Pkwy Merritt Island, FL 32952, 321-452-1233

| Healthcare at Brentwood | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 17 | 17 | 13 | 9 | 4 | 6 | 6 | 6 | 3 | 3 | 2 | - |
| Residents with alarms | 17 | 17 | 13 | 9 | 4 | 4 | 6 | 6 | 3 | 3 | 2 | - |
| Falls | 21 | 16 | 14 | 19 | 23 | 16 | 33 | 23 | 39 | 28 | 14 | 14 |
| Falls with injury | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - |

Healthcare at Brentwood Action Plans

Webinar 1 Action Plan: Meet with residents about preference of alarms. Reduced by 4 by asking residents if they wanted their alarm and staff agreed beneficial to remove them.

Webinar 2 Action Plan: Choosing other approaches besides alarms first so as not to increase number of alarms.

Webinar 3 Action Plan: Reassess residents with alarms to see when their last fall was and determine if alarm is still necessary.

Webinar 4 Action Plan: Start encouraging the use of more walkers for those residents who are able to keep strength up through therapy and restorative.

Webinar 5 Action Plan: Monitor residents alarms were removed from to see if there is a difference in falls or behavioral symptoms.

Webinar 6 Action Plan: Take residents outside. Ordering planters for south courtyard to encourage getting outside.

Webinar 7 Action Plan: Planters installed. Vegetables planted. Residents maintain.

Webinar 8 Action Plan: Putting green purchased for residents to enjoy golf outside.

Webinar 9 Action Plan: Have increased the number of walkers available throughout the building and in certain residents' rooms, doing more walking in building to meals and outside to neighboring sister assisted living.

Webinar 10 Action Plan: Get more volunteers to visit with residents for more activities.

Webinar 11 Action Plan: More individualized activities due to no group activities at this time and scheduling Zoom videos for residents to see and talk to families.

Webinar 12 Action Plan: Home unable to complete due to COVID-19 crisis.
Medical Director updated monthly during QAPI and as needed as new questions/suggestions arise. Continue to re-educate staff during monthly Town hall meetings and as needed as changes arise.

Success stories: By reducing alarms, noise level went down, residents get more sleep, function better and falls reduced. Staff became more aware and made it routine to check on residents more frequently. Residents enjoyed visits from volunteers.

"We learned more about our residents." By encouraging the use of more walkers, there is more walking in the building and outside and over to visit friends at sister assisted living. Residents are getting outside more thanks to new planters which residents maintain, and new putting green made available.

Comment from team: It was a pleasure working with you on this project. I hope the other Consulate HOMES enjoy it as much as we did. Thank you.

Contact: Candy Pederson, Executive Director 2333 N. Brentwood Cir. Lecanto, FL 34461, 352-746-6600

| Regents Park | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 42 | 26 | 32 | 21 | 15 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 42 | 26 | 32 | 22 | 15 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 42 | 33 | 34 | 45 | 48 | 44 | 49 | 46 | 36 | 26 | 28 | - |
| Falls with injury | 0 | 0 | 1 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 1 | - |

Regents Park Action Plans

Webinar 1 Action Plan: Reviewed alarm expense past 2 years, found to be negligible with no impact. Teams acknowledges too many alarms in place and may be increasing falls.

Webinar 2 Action Plan: Team members sat on alarms; felt undignified, disruptive, annoying and inhibited movement. Consensus to remove alarms for culture and benefit of residents.

Webinar 3 Action Plan: Chose one resident with frequent falls as case study with medication review, adjusted psychoactive medication, analyzed daily pattern, now

proactively offer him bathroom after meals and at bedtime with no further falls. Meaningful engagement activity items on each neighborhood for all staff to offer things to do.

Webinar 4 Action Plan: Continue to assess and decrease alarms, monitor residents if increased falls, and continue to engage all staff in in alarm reduction.

Webinar 5 Action Plan: Effective September 1, 2019, it is policy that bed and chair alarms are no longer an option. Continue to educate team members on the 4 P's and an E. Developing neighborhood-specific events to meet specific needs of residents.

Webinar 6 Action Plan: Falls are high on one particular neighborhood between 4-8 PM when the nursing team is working to get residents prepared for dinner, serving and then clean up. Focus on what can be done at those times for more supervision and engagement.

Webinar 7 Action Plan: Came up with a form for staff assignments every 15 min. blocks of time to check in with 3 residents who fall frequently, and they have not fallen. New mantra is "The 4 Ps and an E." Even I.T. knows it. Using positive reinforcement – highlighting when a I's name is NOT on, or has never been on, an incident report. Without alarms it is peaceful, especially at night, calmer on neighborhoods, not as annoying, and you don't hear residents say, "I couldn't sleep because of the alarm."

Webinar 8 Action Plan: Greater attention on meeting bathroom needs more promptly.

Webinar 9 Action Plan: Review night activity and opportunities to modify to promote better sleep. Four Ps and an E laminated signage posted throughout community to remind staff, visitors, ancillary staff of mission. Re-educated team of the 15-minute observation/check in. Now identify fall risk residents on a daily sheet creating accountability for all. Revamped special needs activities now 10:00-11:45 am every day with dedicated team member in each neighborhood and similar offering in afternoon. Rescheduled labs to come in later to promote longer uninterrupted sleep.

Webinar 10 Action Plan: Customer service initiatives include more rapid response to call lights, 4 Ps and an E, resident interventionist who visits and helps oversee high risk residents, concierge more involved with high risk residents and increasing employee motivation practices for greater team member buy in and participation.

Webinar 11 Action Plan: Same as last month.

Webinar 12 Action Plan: We continue to work toward decreasing falls and especially those with injuries. This project has brought us together as a team working to better analyze the root cause and implementing interventions specific to this. Will continue to get more creative with resident engagement.

Meet monthly with medical director to review practices, outcomes and data analysis, he offers recommendations and review of standards of practice. Ongoing management discussion during daily clinical review meetings. Staff education needs are discussed and implemented either in-house or by corporate educator. Meet daily to review falls, conduct an analysis and appropriateness of residents in ongoing initiatives. Corporate Risk Manager has undertaken greater involvement that includes direct observation in the neighborhoods of team members and their responses. She has also had more involvement of review and has identified opportunities for improvement. Education in January was held for short-term neighborhood to discuss ongoing high number of falls which then decreased by almost 50%.

Success Story: Team feels the nice drop in falls by end of Dec. has to do with a new attitude "boots on the ground." Team members are offering a lot of information on residents and ideas more than before. If a resident is falling, there is a more in-depth investigation and a variety of suggestions for solutions. "Before, when alarms were the 'go to,' we got complacent not always thinking things through and now are."

Started and then realized it fizzled out and resulted in an increase in falls so resurrected and revamped The Every 15 min. Observation process. A new high-risk fall list is made every day with team members assigned to identified residents; all staff, not only nursing. Each person signs at the beginning of the hour they are responsible for and signs every 15 min. If a resident has a fall in that hour, the team can better recount what was happening and there is higher accountability for everybody now. Criteria for high risk is more than 1 fall in a week and on average there are approximately 10 residents per day.

Comment from team: Thank you for your guidance and inspiration and I hope we can work together again in the future. You have opened our eyes to a new world we never really thought of, incredibly meaningful and worthwhile. I have to say I am SO incredibly proud of Boca going from so many alarms to zero. We've learned so much this past year and I can't thank you enough for helping us all 'think outside the box '. I'm so happy we signed up for this project.

Contact: Gilda Osborn, ED 6363 Verde Trail S, Boca Raton, FL 33433, 561-483-9282

| River Valley | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 10 | 10 | 11 | 8 | 7 | 7 | 3 | 2 | 1 | 0 | 0 | 0 |
| Residents with alarms | 5 | 5 | 8 | 4 | 4 | 4 | 2 | 2 | 1 | 0 | 0 | 0 |
| Falls | 48 | 31 | 27 | 29 | 30 | 43 | 28 | 33 | 38 | 43 | 23 | 49 |
| Falls with injury | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 4 | 2 | 2 | 0 | 0 |

River Valley Action Plans

Webinar 1 Action Plan: Assess resident behaviors for better understanding of what makes them trigger.

Webinar 2 Action Plan: Assess each resident to see what it is like to wear an alarm. For prior month's action plan, staff are continuing to study what triggers each resident's behaviors which has already shown a decrease in falls from April to May.

Webinar 3 Action Plan: To encourage staff that are not CNA certified to become one even though our company does not require it.  This is a best practice taught in this project to enlarge the team of people qualified to help residents with ADLs particularly the bathroom which tends to lead to falls

Webinar 4 Action Plan: Implementing the four P's and an E in daily routine.

Webinar 5 Action Plan: Increase more independent mobility of the residents throughout the home.

Webinar 6 Action Plan: Implementing more outside volunteer groups, i.e.  4-H to encourage more engagement with residents.

Success Story: Nurses peep in each room and have their "head on a swivel" in a proactive stance. Administrator focus is if a resident can walk, should be. 5 to 10 residents could get out of their wheelchairs.

Webinar 7 Action Plan: Incorporate more music in residents' day-to-day lives.

Webinar 8 Action Plan: Monitor residents' morning wake up patterns. Offer more times to assist residents outside as weather permits.

Webinar 9 Action Plan: Increase meaningful engagement for each resident through various activities offered including in-room for residents who do not wish to participate in activity room. Did experience almost half the number of falls Sept to Oct. and even with more falls since then team feels good that actually fewer resident are falling. Team member are checking in with residents a lot more, CNAs are bringing residents to the Sunshine Room more, increasing activities, such as in Oct. fall festival, peanut fest, goat day, local football game, homecoming parade. Breaks up monotony for residents. Also incorporating a lot more music since November as residents love music. Karaoke, singing and dancing. Every 2 weeks hosting a dance. Also, three residents no longer using wheelchairs.

Webinar 10 Action Plan: Incorporate the "Three D's" of documenting, dialogue of discussion with documentations; offer calendars to each resident.

Webinar 11 Action Plan: Interdisciplinary team participates in 3-2-1 meeting where each resident at risk for injury, pressure sore, or fall is reviewed.

Webinar 12 Action Plan: Continue educating on all of prior action plans; continue completing C.N.A course monthly.

Met ongoingly with medical director about information provided. Education provided to staff on the importance of studying resident behaviors upon hire and annually.

Success Stories: Nurses peep in each room and have their "head on a swivel" in a proactive stance. Is also an attitude that if a resident can walk, should be. Several residents no longer using wheelchairs. Residents transferred into dining room chairs for meals to reduce falls. Incorporating more music in residents' day-to-day lives. Every 2 weeks hosting a dance. Offering more outings, Wal-Mart twice a week. Nurses offering back massages. Offering real life jobs, i.e. assist maintenance including painting interior walls, three cats outside residents enjoy caring for and feeding, also a trained service dog is provided by therapy for companionship. C.N.A course completed with 6 students who are now hired as Personal Care Assistants. Lots of great care plan improvements: incorporate resident's statements in their own care plan after assessing their wants and individual preferences; remove third person from care plans and rewrite based off residents' own desires; re-evaluate each resident to see how they may voice their needs differently, i.e. resident yells out when he needs to use restroom, we will add to care plan that is how he voices his needs; ask residents what their goals are to fulfill their life; ask each resident "What brings you joy?" and try to incorporate what they tell us into their daily life.

Comment from team: Very impressive results. I enjoyed looking at all pictures and results.

Contact: Jessica Price, SDC17884 N.E., Crozier St. Blountstown, FL 32424, 850-674-5464

| Signature Chautauqua | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 26 | 25 | 21 | 21 | 21 | 18 | 15 | 9 | 9 | 7 | 6 | 6 |
| Residents with alarms | 20 | 19 | 18 | 18 | 18 | 15 | 14 | 7 | 7 | 6 | 5 | 5 |
| Falls | 37 | 39 | 36 | 30 | 34 | 33 | 18 | 20 | 33 | 33 | 26 | 16 |
| Falls w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Signature Chautauqua Action Plans

Webinar 1 Action Plan: Introduced project. Reminded all staff to observe needs of residents i.e. slipping down in wheelchair. Monitoring staff to see if they are noticing and intervening.

Webinar 2 Action Plan: Staff check in with residents more frequently to determine if there is a pattern to residents trying to get up – time of day, visitors, activities, specific noises. Work with nurse practitioner to determine if alarms are working for resident or if they are simply in use as a comfort measure for families.

Webinar 3 Action Plan: Bolstering activities to center around people who are falling. Physical games such as Hungry Hippo, noodle basketball, balloon with fly swatters, bowling. "The games knock them out!" Restorative team walking people who are falling, walking to "the game" calling it a pre-game workout. For all residents but strategically for those falling. Making progress, in the past the team would jump to an alarm, not doing that anymore.

Success story: Regarding one resident who was falling a lot, they moved him closer to nurses station, increased checking in with him to each hour predominantly for bathroom needs, has had first round of PT, restorative offers him the "pre-game workout" and he is taking part in the new physical games. He has not fallen since July 6 as of July 25. Was falling quite frequently, 3 to 5 times a week in fact.

Webinar 4 Action Plan: Have care plan meetings with families in order to provide better education and show them the "new and improved" methods of preventing falls.

Webinar 5 Action Plan: Incorporate restorative programs in fall prevention plan. Create events in Activities to occupy high risk fall residents. More frequent checking in by direct care staff as well as managers. Currently using the "tag out" program where managers "tag" the CNA's so that they can check in on high risk fall residents without having to stop for call lights. One family agreed to try our new programs and we will try to use this as an example to the other families. Used our "Senior Olympics" preparation as a restorative and core strength work out with our high-risk fall residents. One of them even participated in the actual event and hasn't fallen since. Added 3 more residents on top of last month's 2 residents to our walk to dine. Have already seen a great benefit from this exercise.

Webinar 6 Action Plan: Continue to use sports themed restorative during football season to increase exercise, dexterity, endurance, and mobility. Nine new residents walking to dine.

Webinar 7 Action Plan: Implemented restorative as part of our anti-fall initiative. This has proven successful and will be incorporated for future use. Also, the "tag out" project has helped in monitoring activities that might lead to falls. This also gets the department heads involved in a direct care basis. Working with volunteers, training on what to look for and what to report.

Webinar 8 Action Plan: Rest stations have been strategically placed throughout the building so that our high fall risk residents have a place to sit and see the goings on. This has been a

huge success so far with a huge fall reduction. Also, recent meetings with family members have resulted in 2 alarm removals.

Webinar 9 Action Plan: Continuation of previous action plans. Researching lavender scent dispersion for its calming effects. Working to build covered outdoor area. Educating remaining families of residents with alarms on alternatives to help residents achieve their highest practicable level of wellbeing.

Webinar 10 Action Plan: Continue with previously stated action plans. Ongoing education provided to staff, residents, and family members about the initiative to reduce/eliminate alarms. Steady progress towards reduction. Restorative has new exercise activities including volleyball and is currently at highest caseload ever. Restorative and ADONs from each unit are working closely together and meeting daily to identify needs of residents.

Webinar 11 Action Plan: Route 66 competition logging miles walked. Wears residents out, they have a good nap and do it again. Like the Boston Marathon.

Webinar 12 Action Plan: Going to consider Fall Champions learned from Signature-Washington.

Medical Director attends monthly QAPI meetings and care plans when available. He reviews restorative plans and falls. Best practices are reviewed and revised during monthly QAPI meetings, Quarterly Facility Advisory Board Meetings, and Daily Clinical Meetings. Information shared during shift huddles, communication visual aide boards. Also purposefully decreased availability of alarms early on.

Success stories: Working toward night check-ins based on resident need as opposed to scheduled. Lots of creative physical offerings: Hungry Hippo, noodle basketball, balloon with fly swatters, bowling, volleyball. “The games knock them out!” Restorative team walking with residents to “the game” calling it a pre-game workout and Route 66 goals mimicking a marathon. For all residents but strategically for those falling. Team no longer jumps to an alarm.

Families cannot come in right now, maybe in our favor no offense to families, also more receptive to what we are advising including not using alarms. Communication better, Outpouring of care. Different vibe right now. Trusting us.

Contact: Graham Campbell-Work, ED 785 S. 2nd St., Defuniak Springs, FL 32435

| Signature Peninsula | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 |
| Residents with alarms | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 |
| Falls | 23 | 18 | 16 | 15 | 19 | 9 | 14 | 13 | 20 | 21 | 16 | - |
| Falls with injury | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Signature Peninsula Action Plans

Webinar 1 Action Plan: Review residents currently utilizing alarms for effectiveness and educate new hires to explain why we are alarm-free, explaining the cons of alarms in our center. Medical director has been involved with alarm-free initiative from the beginning and is very supportive of the initiative, as he agrees with the cons of alarms. Have an alarm-free approach and only utilize alarms as a final approach for falls. Working to not allow additional alarms and review current alarm usage and effectiveness on those residents currently using alarms during care plan meetings and as needed.

Webinar 2 Action Plan: We mean to trial those residents that are using alarms and trial them to not have the alarm on during different time frames to see if it would be beneficial to remove. One resident is going to be a challenge because the alarm is very family driven, but it is something we would like to try to become completely alarm free in our center.

Webinar 3 Action Plan: No longer using alarms as a practice. Will continue to discuss other alternatives with the family members that are requiring us to continue using alarms with their family members to try to consider trialing times again to remove alarms.

Webinar 4 Action Plan: To discuss approaches with maintenance to implement handrails/grab bars in room of resident with alarm near door. Resident with alarm with recent return from hospital, plan to reduce time spent "alarmed."

Webinar 5 Action Plan: Send out The False Assurance of Resident Alarms brochure to all families, added to resident resource manual, collaboration with new medical director who is "on board" to replace alarms.

Webinar 6 Action Plan: Start gardening to increase resident movement and to work on the power of sleep by investigating use of longer wear incontinence products. Also added them to budget formulary. Continued resident involvement in jobs- purposeful- involve 5 new residents this month. Increase off time for resident alarms

Success Stories: Have several examples of due to checking in more frequently and helping to the bathroom, fewer falls. One resident feeds the turtle daily, this gives her purpose and

because falls were behavioral-related, this seemed to stem them and she had no falls in Sept. Housekeeping team is looking for signs of distress/potential falls and "we do 4 Ps and E." Therapy does include helping resident to bathroom in OT and PT! Five residents run the coffee shop.

Webinar 7 Action Plan: We are continuing with purposeful jobs and increased alarm removal. Use of lavender for high fall risk residents. Continued collaboration with families on alarm reduction- one to be discontinued by year end.

Webinar 8 Action Plan: Continuing more meaningful jobs for residents. Collaborate with care givers on initiatives to honor sleep.

Webinar 9 Action Plan: No alarms! Still working on meaningful jobs- this will continue to increase resident involvement. Working on dining room help with resident as a lead. Uninterrupted sleep- to provide education to Resident Council and next meeting to provide fact sheet.

Webinar 10 Action Plan: Continue meaningful jobs. Incorporate dog in fall prevention, develop brochure for meaningful sleep.

Webinar 11 Action Plan: Continue plans in particular resident jobs even with coronavirus, utilizing and giving purpose to residents.

Webinar 12 Action Plan: Continue previous plans with focus on uninterrupted sleep and purposeful jobs. Continue culture of no alarms.

Continued collaboration weekly with medical director and incorporation in QA. Daily huddles with continued plan.

Success Stories: One resident not falling as much; have implemented books, magazines, checking more frequently, more activities, more out of room at nurses' station and offered a book to read. Lavender lotion was used with one resident who is sleeping better and has had no falls. Activity director created brochure for residents and families regarding the importance of sleep and ideas to enhance sleep. Three residents are drinking chamomile tea in an attempt to reduce hypnotics, worked then that resident told other residents. Great project – brought more focus to plans with focused follow up and new ideas! Thank you!

Contact: Ryan Dulski ED 900 Beckett Way Tarpon Springs, Florida 34689, 727-934-0876

| Signature The Courtyard | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 16 | 16 | 16 | 10 | 6 | 6 | 6 | 7 | 8 | 6 | 5 | 5 |
| Residents with alarms | 13 | 12 | 12 | 6 | 4 | 4 | 4 | 7 | 5 | 3 | 4 | 3 |
| Falls | 14 | 23 | 37 | 15 | 24 | 18 | 27 | 17 | 22 | 23 | 20 | - |
| Falls with injury | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 1 | - |

Signature The Courtyard Action Plans

Webinar 1 Action Plan: Each team member developed an individualized plan for one resident to promote choice and meaningful engagement based on that person's schedule, likes, and history.

Webinar 2 Action Plan: Looked at each elder individually and developed an individual plan based on the Elder's preferences, medications, fall history, and sleep patterns.

Webinar 3 Action Plan: Invited Mission Team (volunteer corps of residents) to check in with residents. Education and utilizing the Quest (communication) Board to focus on fall prevention by using immediate problem solving and creative ideas instead of alarms.

Webinar 4 Action Plan: Continue Mission Team (volunteer residents) to check in proactively with residents. Continue to educate and utilize our Quest Board to focus on fall prevention by using immediate problem solving and creative approaches instead of alarms.

Webinar 5 Action Plan: Continue Mission Team checking in, implementing the 4 P's and an E, Ambassadors checking in, creating an Exit Line for each person to use when leaving a resident, looking for new ways to encourage movement.

Webinar 6 Action Plan: Implementing the 4 P's and an E through education and include in our Ambassador checks. Exit line now is: "Is there anything else I can help you with?" Asking elders what kind of movement do you enjoy? Each manager has been challenged to increase mobility with one resident each week then challenge another stakeholder and so on. Restorative and Quality of Life teams are focusing on ways to improve and encourage movement in each encounter with the elders.

Webinar 7 Action Plan: More deliberate questioning during move in regarding falls. Family volunteers checking in. New fall approaches for one resident falling.

Webinar 8 Action Plan: Growing the proactive checking in by resident volunteers. Involving families in proactive checking in. Digging deeper into history of residents who fall frequently at home during life history.

Webinar 9 Action Plan: Ask residents their preferences for a good night's sleep.

Webinar 10 Action Plan: Trying more frequent checks on new residents to see if falls affected in first 48 hours. Will try lavender lotion. Like managers, now all stakeholders have been issued the challenge to increase movement with one resident per week. Discuss mobility in care conferences. Ask more detailed questions when moving in. Three family members identified to invite to check in with residents.

Webinar 11 Action Plan: Continue to find ways to engage stakeholders by having items for them to offer elders, i.e. mints, etc. Restart proactively checking in more frequently with new residents in first 48 hours.

Webinar 12 Action Plan: We want to continue to reduce/eliminate alarms. Continue to meet and discuss falls/alarms and develop inventive ways to engage elders.

Medical director is engaged at monthly at-risk meeting, weekly rounds and as needed. Competency taught through training, routine supervision, and huddles. Information shared via IDT meetings, huddles, and updating care modules. Sustainability via morning meetings, clinical meetings, huddles and town hall meetings.

Success Stories: One resident represents most of increased falls in June. We discussed him during June coaching call and team implemented increased checking in, noise canceling headphones, chaplain visits and praying with him, keeping on the same routine which works well for him and ensuring team members know these things via huddles and modules and he has not fallen. Another resident team is keeping blinds open, trying to keep light on in room too (although she turns off) and no falls since. Another resident who was falling and we brainstormed had a room change, roommate is more social which seems to be helping him, they are talking to each other, not lonely, engaged, proving the theory of meaningful engagement to prevent falls. Family brought photographs from home also which he is enjoying. Administrator shared that the "coaching call helped us with individuals based on what we learn."

Team had fun increasing physical events: corn hole, soccer, volleyball, practicing sports for Senior Olympics with sister homes, and the Courtyard Boogie, dancing every day to music.

The creative administrator posed a challenge to managers only to engage a resident physically every day. He wanted managers to go first before issuing the challenge to all team members. In Jan. team realized that many team members are doing this already on their own even though it was never given as a formal challenge. It has simply caught on.

Contact: Brad Nobles ED 2600 Forest Glen Trail Marianna, Florida 32446, 850-526-2000

| Signature Washington | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 26 | 23 | 15 | 12 | 14 | 16 | 15 | 12 | 0 | 0 | 0 | 0 |
| Residents with alarms | 19 | 14 | 14 | 11 | 12 | 12 | 12 | 9 | 0 | 0 | 0 | 0 |
| Falls | 31 | 30 | 27 | 22 | 42 | 40 | 27 | 30 | 17 | 25 | 29 | 33 |
| Falls with injury | 2 | 0 | 1 | 0 | 2 | 1 | 0 | 1 | 1 | 2 | 0 | 0 |

Signature Washington Action Plans

Webinar 1 Action Plan: Get more of the IDT involved in this better practice project. Have brought more of the team into calls and webinars. Response is positive, seems a little quieter.

Webinar 2 Action Plan: Create an educational brochure to heighten awareness regarding the negative effects of alarm use. Brochure highlighting progress was created and placed around building.

Webinar 3 Action Plan: Incorporate resident preferences. Talk in huddles about resident wishes. Involve CNAs in care planning; anything that might help resident is added. Getting all staff to check in more frequently.

Webinar 3 Action Plan: Using individualized bathroom use tracker for individuals who have had falls in bathroom to anticipate bathroom needs avoid future falls of this nature.

Webinar 4 Action Plan: Risk manager to do interactive training during huddles on proactive fall prevention.

Webinar 5 Action Plan: Improve resident exercise offerings to include Zumba, Pre-game workouts, Strength training, weights, and Thera-bands.

Webinar 6 Action Plan: Identified 3 residents to implement family education and alarm reduction trials on.

Webinar 7 Action Plan: Plan to have all alarms discontinued as of 12/31/2019.

Webinar 8 Action Plan: Assess resident sleep preferences by establishing a questionnaire of personal preferences which enhance sleep and add to care plan.

Webinar 9 Action Plan: Encourage more residents to work in the country store, deliver mail, encourage prepare dining room for meals.

Webinar 10 Action Plan: Change verbiage concerning care planning such as care plans to Growth Plans, problems to Needs, change goals to my goals and interventions to individualized approaches.

Webinar 11 Action Plan: Ensure highest level of physical, mental and psychosocial wellbeing are care planned. Utilize Full Life Conferences which take place within the first 72 hours of move in to gather information from the resident and family to then ensure baseline plan of care is more resident centered as well as individualize and establish plans of care for the future of the resident in our home.

Webinar 12 Action Plan: Continue current practices of fall prevention education and remain alarm free in the future.

Medical Director comes at least weekly and to monthly QA meetings. This information is provided to stakeholders through live, hands on and verbal demonstration and education. Information distributed during weekly at risk and monthly QA meetings. Project handouts emailed to IDT members. Discuss alarm reduction during morning clinical meetings.

Success Stories: A CNA took a resident outside which calmed her down. Now offering a few minutes in courtyard each day, short walks and do use gum with one resident. Gum and outside more are next steps. Just go outside, give permission.

Risk manager initiated interactive training during end of shift huddle on resident specific approaches for proactive fall prevention. Staff who excelled in these areas were named Fall Prevention Champions and received small prizes. These Champions then continued the education with other stakeholders, family members and residents to enhance sustainability of fall prevention.

Learned best practice is not using bathroom tracking but instead knowing resident routines, desires, and understanding what wellbeing really means to that individual. This gives all the information needed to grow a trusting and warm relationship. Team learned it truly helps to know those you care for and have a personal connection so you can not only learn/know routines but also to be able to anticipate needs. During one of the coaching calls, CNAs shared that tracking bathroom use is not needed if you just know your people and check in with them proactively and frequently also because even if a pattern it can fluctuate. They also said the more you observe and know what to look for, that is the key.

Discussions with families of residents using alarms revealed that one family member thought the alarm was only way for the resident to get help, she forgot that residents have

a call light plus staff go to residents at least every 2 hours. Felt good to be able to educate her and help her fears to be allayed and move toward not having an alarm.

Comment from team: Thank you for involving us in this project. Improved quality of life for our residents.

Contacts: Hannah Peters DON and, Lisa Hood ADON 879 Usery Rd. Chipley, FL 32428, 850-638-4654

| Sunset Lake | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Residents with alarms | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Falls | 31 | 18 | 21 | 25 | 32 | 24 | 16 | 25 | 7 | 20 | 11 | 10 |
| Falls with injury | 0 | 0 | 2 | 0 | 2 | 1 | 1 | 0 | 0 | 1 | 0 | 0 |

Sunset Lake Action Plans

Webinar 1 Action Plan: Harms of Alarms education from project first webinar.

Webinar 2 Action Plan: Educate residents' families on risk of alarms, post next webinar for residents and families to attend; discussed in operations meeting with regional nurse and operation leadership of project and benefits; last month action plan ongoing with increasing staff awareness and involvement to reduce use of alarms, provide education, and discuss in town hall meeting.

Webinar 3 Action Plan: Educate staff for plan of identifying bathroom needs, assistance level, and schedule tailored to each individual. Start 3-day bowel and bladder diaries to accurately identify bathroom pattern. Focusing on individual bathroom needs seems to be translating into falls trending down.

Webinar 4 Action Plan: Continue bowel and bladder diaries on 5-10 residents at a time; Education with all staff on the 4 P's and an E to ensure all staff checking for residents' most frequently needed assistance that cause falls and revise Guardian Angel checks to include 4 Ps and an E.

Webinar 5 Action Plan: Focus on maintaining mobility and strength; reviewing residents in restorative; ensuring therapy is screening residents quarterly for any changes that may need maintenance; training CNAs to assist residents to walk to and from dining room with walker.

Webinar 6 Action Plan: Identifying and educating 5 family members and 3 new volunteers to assist the community with engaging residents; activity calendar to include at least 15% physical activities; begin discussing individualized care plans for engagement; and begin reinforcing The Power of Language.

Webinar 7 Action Plan: Involve family members in discussions of individualized care plans for engagement for each resident. Reinforce the Power of Language with community – use "events" instead of program or activity, use "approach" instead of intervention.

Webinar 8 Action Plan: Team to focus on eliminating sleep distractions and continue to offer Always Available meal items to offer outside of general mealtimes; re-implement fall reduction competition and the card game to encourage staff participation; post monthly fall numbers by time clock to increase awareness and engagement with initiative.

Webinar 9 Action Plan: Invited families to take part in this initiative to reduce alarms and falls giving families purpose. Taught the 4Ps and an E. Are responding well and appreciate the invitation, want to help. For instance, a nephew to one resident comes every day and since inviting his participation, he attends activities, wears silly hats, visits with other residents and keeps an eye out for residents besides his aunt. He was a schoolteacher and appears to enjoy the social interaction. Company had an initiative a year ago to foster relationships with families; to impress upon them they are not a nuisance, they are partners. This seems to have set the stage for increased family involvement and interest in checking in with other residents.

Webinar 10 Action Plan: Develop a Welcome Committee and Transition Plan for new residents and family members. The Committee will welcome and assist resident to adjust to the new environment and offer the event schedule based on personalized needs.

Webinar 11 Action Plan: During the March coaching call team said plan had been to start a Welcome committee and create a personalized action plan for each new resident.

Webinar 12 Action Plan: During the March coaching call team said plan to start the Welcome committee and personalized action plans for each new resident.

Medical director has monthly participation. Incorporate initiatives and progress through Quality Assurance and Performance Improvement Committee meetings. Leadership is educating during Town Hall and small group meetings, as well as providing counseling on 1:1 basis. Team shares results and improvements through Regional Operation meetings monthly.

Success Stories: Discontinued an alarm early on in the project because realized alarms are probably more of a cause than solution. Made one resident agitated, tried to turn off and would fall. Stopped the alarm in Sept. and no fall since and resident seems better off. Have

lots of focus on engagement and mobility from a company perspective increasing physical activity, walk to dine, what can we do to keep residents moving. New DON eliminated alarms at a former building, stating, “Really there was no increase in falls.” And, her opinion of alarms after being a DON of many years is that “they are ineffective anyways.” Administrator kind of said what is part of the focus of this project, “The way the culture is going, the expectation is regular daily living.”

Falls really dropped in the last two months of the project. Reasons given were: proactive rounding, including residents and family, Guardian Angel rounds, more communication, more engagement, utilizing all staff and volunteers, partnering with school so have hospitality aides and the company has a concurrent initiative to focus on physical activity. Trying to provide more mobility beyond restorative which also feeds into sleep.

Team said they are more person-centered now, adjust sleeping schedules, proactive with restroom use, open dining now and all this will be the “new norm.” They are purposefully developing relationships with students in health care i.e. Amer Red Cross, vocational tech, and other schools because students have not yet learned the old culture. Providing more music and movement one team member found and gave a resident the gift of old vintage record player.

This was our pleasure. We appreciate the feedback and ideas, especially on the Welcome Committee.

Contact: Devin Eickelman, Asst. Admin. 832 Sunset Lake Blvd, Venice, FL 34292

| Ybor City | April 2019 | May 2019 | June 2019 | July 2019 | Aug 2019 | Sept. 2019 | Oct. 2019 | Nov. 2019 | Dec. 2019 | Jan. 2020 | Feb. 2020 | Mar. 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 8 | 7 | 7 | 9 | 5 | 10 | 8 | 6 | 10 | 6 | 11 | 8 |
| Falls with injury | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Ybor City Action Plans

Webinar 1 Action Plan: Introduced project. Information from webinars will be passed on to nursing team members first.

Webinar 2 Action Plan: Update Performance Action Plan regarding fall reduction to assess new residents thoroughly for fall risks, conduct thorough accident investigations – getting statements from everyone, to uncover root cause, and resident education regarding poor safety awareness.

Webinar 3 Action Plan: Education about proactive prevention ideas such as anticipating needs at Town Hall all staff meeting.

Webinar 4 Action Plan: Safety committee adopted measure from coaching call to insert handrail on slope in courtyard, slope is within ADA regs; Town Hall all staff meeting to include training on anticipating needs to prevent falls; and follow up with restorative nurse regarding incontinent products for longer wear at night, to reduce sleep interruption.

Webinar 5 Action Plan: Yard games or physical games and will give money for supplies; using longer wear incontinence products now, have really made it individual; handrail now in place outdoors. Have been educating staff and will more this week at a Town Hall meeting.

Webinar 6 Action Plan: Educate staff on Best Practices as we move through this program. New nurse Risk Manager/Staff Development Coordinator to assist administrator with the staff education; have rolled out the new incontinence products that are more absorbent for nighttime use; plan to include Fall Reduction Training in our nursing staff competency process.

Webinar 7 Action Plan: Have a new Risk Manager responsible for properly investigating falls and putting fall prevention plans in place. Also, she educates team members pushing them to think of new ideas for reducing falls and including on care plans. All staff training on watching out for proper placement of resident personal items to ensure residents have in easy reach; and educating all staff to ask residents if there is anything else staff can get them before exiting the room. Including fall reduction best practices in all-staff Townhall meeting. Plan to involve the CNAs more in the resident care plan process.

Webinar 8 Action Plan: Continue training and coaching on proper use of new more absorbent incontinent products. Have conducted re-training on nursing staff on lifts and the proper use and inspection of slings; found a sling with damage that did not involve an incident, but felt the staff needed re-training on what to look for and not use properly. Also, re-education on investigating falls and putting plans in place to prevent.

Webinar 9 Action Plan: Campaign to make the 4 Ps and E concepts visible to staff in employee breakroom and in the all-staff Townhall training. Will continue training and coaching on proper use of new more absorbent incontinent products. Risk manager still training how to properly investigate falls and putting plans immediately or as soon as possible to hopefully prevent a reoccurrence.

Webinar 10 Action Plan: Campaign to make the 4 Ps and E concepts visible to staff in the employee breakroom and in the all-staff Townhall training. Education related to reducing falls, since fall numbers went up. Continue training and coaching on proper use of new

more absorbent incontinent products to support uninterrupted sleep. Risk Manager trains nurses how to properly investigate falls and put plans in place immediately or as soon as possible to hopefully prevent a reoccurrence.

Webinar 11 Action Plan: Continue above plans.

Webinar 12 Action Plan: Continue above plans and complete a staff competency tool to teach and evaluate CNAs, nurses and other staff in new-hire orientation and annually. Activities director looking for sources for visiting animals.
Medical Director is engaged, asks questions, interact monthly with QAPI meetings. Alarm free is the trend.

Adopting measures at the QAPI meetings in terms of Action Plans and training initiatives. New regional nurse made aware of our participation in this program. Risk Manager conducts team huddles after a fall occurs. Risk Manager and NHA to continue to training staff on Best Practices at staff education sessions, such as monthly Townhall meetings and during nursing staff education. Ideas shared from coaching calls and webinars with managers for buy-in and further teaching.

Success Story: After the first webinar, The Harms of Alarms, team quickly decided to stop including alarms as part of the "toolbox" to prevent falls. One resident falling less frequently due to increased observation put in place and better positioning with a new reclining wheelchair.

Risk manager working on competency tool for 4Ps and an E, only team doing this. Interesting idea came up in this team: the longer wear incontinent products are more expensive, however, they involve less hands-on by team members and potentially prevent falls by sleeping better. Asked if any of that could be captured that in figures/money. And this team has seen some improvement with falls at night due to the longer wear incontinence product.

Comment from team: 4Ps and an E was one of the big "take aways" especially personal items within reach. Thank you for allowing us to join we have definitely learned a lot.

Contact: Brian Pollett ED 1709 N. Taliaferro Ave, Tampa, FL 33602 813-223-4623

## 4. Webinar Survey Results

Scale of (low) 1, 2, 3, 4, 5 (high) was used.

Webinar 1 The Harms of Alarms – May 3, 2019 (for April)
Was this webinar educational? Average = 4.2
Was this webinar inspirational/motivational/encouraging? Average = 4.2

Comments: The information presented was very educational and we have reviewed most of this information in the past, as we moved to be alarm free prior to this webinar, but it was helpful to re-educate our staff. We all liked relating the negative effects to pressure ulcers, etc. It gave us additional reasons to educate our staff in those areas.

Webinar 2 Alarms: The New Deficient Practice – the 7 CMS regulations that could be cited May 31, 2019
Was this webinar educational? Average = 4.6
Was this webinar inspirational/motivational/encouraging? Average = 4.6
Comments: We liked the language creates culture slide and we would like a copy of that slide to introduce that to help our culture in our center.

Webinar 3 Better Practice #1 Mobility – June 28, 2019
Was this webinar educational? Average = 4.5
Was this webinar inspirational/motivational/encouraging? Average = 4.5
Comments: Can you please send the presentation that you used today or the links around the culture change languages? I think that was very helpful and something that we could implement in our home.

Webinar 4 – Better Practice #3 and #4 Proactively checking in with residents - July 26, 2019
Was this webinar educational? Average = 4.6
Was this webinar inspirational/motivational/encouraging? Average = 4.6

Webinar 5 - Mobility – Aug. 30, 2019
Was this webinar educational? Average = 4.6
Was this webinar inspirational/motivational/encouraging? Average = 4.5

Webinar 6 - Using Meaningful Engagement Proactively to Prevent Falls – Sept. 27, 2019
Was this webinar educational? Average = 4.7
Was this webinar inspirational/motivational/encouraging? Average = 4.9Comments: "Very motivating- quality of life director ready to institute many ideas into calendar."

Webinar 7 Lots of Other Best Practices to Reduce Falls and Replace Alarms Friday, Oct. 25, 2019
Was this webinar educational? Average = 4.8
Was this webinar inspirational/motivational/encouraging? Average = 4.75

Webinar 8 Honoring Sleep and Open Dining Friday, Nov. 22, 2019
Was this webinar educational? Average = 4.75
Was this webinar inspirational/motivational/encouraging? Average = 4.75
Comments: "Very educational, love the ideas."

Webinar 9 Highest Practicable Level of Well-being as required by CMS regulations Friday, Dec. 20, 2019
Was this webinar educational? Average = 4.65
Was this webinar inspirational/motivational/encouraging? Average = 4.67
Comments: "Loved the videos."

Webinar 10 The Eden Alternative® 7 Domains of Well-being – Now part of CMS Requirements Jan. 31, 2020
Was this webinar educational? Average = 4.6
Was this webinar inspirational/motivational/encouraging? Average = 4.8

Webinar 11 Individualized Care Plans to include Better Practices Friday, Feb. 28, 2020
Was this webinar educational? Average = 4.8
Was this webinar inspirational/motivational/encouraging? Average = 4.8

Webinar 12 End Results of Project/Lessons Learned/Send Off Friday, Mar. 27, 2020
Was this webinar educational? Average = 4.7
Was this webinar inspirational/motivational/encouraging? Average = 4.9

## 5. Project Successes and Failures

Of the 10 homes, 5 got to zero alarms at different stages. The earliest was in the first month, then within 6 months, 8 months, and 9 months. By the end of the year, the five homes still with alarms had significantly reduced the number of alarms. Typically, the few remaining are because of family members insisting on their use but with time and education, they often end up seeing the value of the other practices instead of alarms.

Alarms at the start of the project in April 2019 in total were 164. By the end of the project March 2020 alarms in total dropped to 18.

Residents with alarms at the start of the project in April 2019 in total were 143. By the end of the project March 2020 residents with alarms dropped down to 15.

Falls do trend down in most cases, thankfully, although not all and there is fluctuation month to month. Teams were thrilled of course when falls trended down.

Early on the following phenomenon was seen, that the more practices a home implements tends to translate into fewer falls.

Many teams said this in various ways that removing alarms forces team members to be more creative and individualized rather than just jumping to using an alarm as was done for many years.

To assist teams with a shortage of time, will offer to ask survey questions over coaching calls in order to obtain webinar surveys and monthly action plans and not have to repeatedly request them.

Participants shared that they loved videos and loved hearing from each other so will definitely include videos again and maybe more of them and may include more reporting out from teams in the project.

Thank you to the Florida state survey agency and CMS Region IV for supporting this project. The number of residents having to live with noisy alarms was brought almost to zero and we can say that many residents also experienced fewer falls which were precisely the goal of the project. Thank you to the 10 homes who committed and stayed with the project even in the first months of the COVID-19 pandemic, you are to be commended and you are truly the heroes.

Final Report April 2019 – March 2020
Submitted by Carmen Bowman, Edu-Catering, Project Coordinator

**Replacing Alarms and Reducing Falls with Better Practices Project**
**Sponsored by Edu-Catering and the State of Florida, Agency for Health Care Administration**

**Final Year 2 Report Aug. 2020 - July 2021**

This report consists of the following required updates:
1. Summary of project participation
2. Resident outcome data
3. Nursing home team action plans
4. Webinar survey results
5. Project successes and failures

## 1. Summary of project participation

No home dropped out over the entire year even with enduring the pandemic the harder months of the staffing shortages resulting from COVID.

In this second year of the project (Aug. 2021-July 2021), total number of alarms dropped from **138 to 3**; and the number of residents using alarms dropped **from 132 to 3. Only three alarms left, 1 in each of three buildings only.**

In comparison, during Year 1 (Feb. 2019 – Mar. 2020), alarms dropped **from 164 to 18**; and number of residents with alarms dropped **from 143 to 15**.

Although falls did not decrease every month for every home, many positive outcomes resulted as a result of the project. Teams identified that oftentimes increases in falls happens when new people move due to medication or other complications contributing to the higher number of falls while the team feels good about the number of residents falling usually had decreased.

The following positive outcomes were experienced both during Year 1 and Year 2:

- Increased team involvement in preventing falls
- Increased individualized ideas for preventing falls
- A quieter atmosphere for all
- Falls trended down in most cases when staffing was stable

The following were also reported by Year 2 teams:

- Getting to know details of residents' lives; purposefully discovering details during move in from the resident and/or family
- More individual care plans

- Anticipation of resident needs, particularly bathroom but also personal items near the person
- Proactive checking in with residents by a much wider team and more often

Homes that got to zero alarms during the project are the following and their statistics: Lake Mary 35 to 0, Rio Pinar 30 to 0, Rosewood 28 to 0, Osprey Point 9 to 0, San Jose 6 to 0, Coral Trace 4 to 0 and Bradenton 4 to 0, Oaktree 4 to 0.

Marshall alarms decreased from 10 to 1, and University Hills 9 to 1, Governor's Creek started with 1 and remained at 1 (working with an insistent family).

Three homes, Tallahassee, Pensacola and Orange Park started with zero alarms and remained at zero alarms.

As a result of alarms being replaced by better practices and a national trend including in the state of Florida to no longer use alarms, permission was granted by the CMS Region IV office to eliminate the requirement that a nursing home still uses alarms to be in this project. This is a very positive happening.

Of 14 homes, 8 experienced a decreased average number of falls per month; 2 remained the same and 4 increased. Some homes got hit harder with covid and staffing challenges:

| AVERAGE FALLS/MONTH | Pre-Project 12 Months Aug. 2019-July 2020 | Project 12 Months Aug. 2020-July 2021 |
|---|---|---|
| Bradenton | 189/12=16 | 197/12=16 |
| Coral Trace | 292/12=24 | 348/12=29 |
| Governors | 158/12=13 | 142/12=12 |
| Lake Mary | 426/12=36 | 413/12=34 |
| Marshall | 316/12=26 | 212/12=18 |
| Oaktree | 125/12=10 | 94/12=8 |
| Orange Park | 265/12=22 | 215/12=18 |
| Osprey | 176/12=15 | 211/12=18 |
| Pensacola | 169/12=14 | 155/13 |
| Rio Pinar | 410/12=34 | 450/12=38 |
| Rosewood | 165/12=14 | 171/12=14 |
| San Jose | 312/12 = 26 | 192/12=16 |
| Tallahassee | 163/12=14 | 114/12=10 |
| University | 107/12=9 | 227/12=19 |

In each of the 14 homes, better/culture change/proactive/more individualized practices are being implemented rather than alarms. See both a record of action plans and outcome results here below for each participating home.

## 2. Resident outcome data AND 3. Nursing home team action plans

| Osprey Point | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 9 | 9 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 9 | 9 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 19 | 17 | 10 | 18 | 23 | 20 | 19 | 3 | 12 | 4 | 24 | 15 | 27 |
| Fall w/ injury | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

**Osprey Point Nursing Center**

Contact: Jonathan Weiss, Executive Director

1104 N. Main St. Bushnell 33513 352-568-8777

Webinar 1 Action Plan: Our plan is to educate all staff on the negative impact of alarms, to encourage culture change with the alternative methods identified in the webinar and to maintain current information through continued research.

Webinar 2 Action Plan: Educate ALL staff on the false assurance of alarms with brochure as handout and Q&A session. Complete a screen for bathroom preferences upon move in along with fall assessment.

Webinar 3 Action Plan: Educate ALL staff on the false assurance of alarms with brochure as handout and Q&A session Continued training and development of staff to reinforce strategies. Need to establish individual bathroom routines.

Webinar 4 Action Plan: Continued training and development of staff to reinforce strategies. Need to establish individual bathroom routines. Re-assessment of residents for alarm.

Webinar 5 Action Plan: Bird feeders at windows, Balloons hung outside of the windows for special occasions like birthdays.  Colorful clings on the windows.

Webinar 6 Action Plan: Continued training and development of staff to reinforce strategies. Need to establish individual bathroom routines. We are continuing with bathroom routines and trying to incorporate all disciplines in increasing mobility.  We have been hit hard with COVID this second round, so we have had a shift in focus.

Webinar 7 Action Plan: To use the iPad for music; lavender and oils during 1:1s.

Webinar 8 Action Plan: We have been trying to liberalize the med pass at nights to encourage better sleep, however with staffing challenges, this had to be delayed.

Webinar 9 Action Plan: Decided to put the poster of the 4 Ps and an E in rooms as a reminder and MDS Coordinator offered to get on care plans things that matter and we've learned in this project: outdoors, music, sleep, items needed around me, and highest practicable.

Webinar 10 Action Plan: Think of/encourage other activities for residents, especially 1:1 (inspired by the resident vacuuming story in Webinar 10). Initiate a culture change by the way that questions, statements, and other words are said. Make care plans even more personalized and continue to hold committees for new ideas. Continue to brainstorm on new ideas to prevent falls. Continue the Performance Improvement Plan already set in motion to remove unnecessary side rails on beds to prevent falls. Always implement the 4 Ps and an E for focused quality of care and preventing falls.

Webinar 11 Action Plan: Osprey Point – was asked numerous times and just couldn't pull it off with so many staffing shortages, changes and even sickness.

Webinar 12 Action Plan: Utilize essential in the shower room and resident rooms, for example: lavender sprays and lotions to determine if it has a calming effect on residents. Music is utilized by placing radios and CD players in resident rooms, sometimes portable CD players and radios, to play a resident's preferred music. Some residents love Gospel, which makes residents much happier and more likely to have better wellbeing.

Medical director involved in monthly QAPI. Competency- based evaluations to be prepared and used as evaluation tool.

Success story: "Helping residents to get up and use the bathroom increases mobility. And needing to use the bathroom wakes us up, all the more reason to be alert and anticipate BR needs." Patricia Joseph, ED CHC Osprey Point 2nd quarter - Everyone is more aware of residents and what they are doing. More focused on those who are falling more, more familiar with their bathroom routine. For example, have learned a cue for some in wanting to get up means they need a snack or coffee. 3rd quarter – Working toward open dining times to serve individual preferences of residents better so not sitting waiting for food and honor sleep and honor food preferences desire a personalized med pass as well, working toward it. 4th: 4 Ps and an E poster in resident rooms as a reminder to all who go in and out. Keep reminding everyone to ask the 4 Ps and an E. MDS Coordinator to get on care plans things that matter, and we've learned in this project: outdoors, music, sleep, items needed around me, and highest practicable. Thinking of and encouraging other meaningful engagement for residents, especially 1:1 - inspired by the resident vacuuming story in Webinar 10 - The Eden Alternative Domains of Wellbeing.

| **Marshall** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 10 | 10 | 6 | 2 | 2 | 4 | 2 | 1 | 2 | 2 | 1 | 1 | 1 |
| Residents with alarms | 6 | 6 | 6 | 2 | 2 | 4 | 2 | 1 | 2 | 2 | 1 | 1 | 1 |
| Falls | 18 | 11 | 7 | 17 | 24 | 36 | 15 | 16 | 17 | 25 | 10 | 7 | 9 |
| Fall w/ injury | 0 | 0 | 0 | 2 | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |

**Marshall Health and Rehabilitation Center**

Contact: Brittany Harris, DON

207 Marshall Dr. Perry FL 32347 850-584-6334

Webinar 1 Action Plan: Ad hoc and PIP to introduce to management team, all of IDT to watch webinar.

Webinar 2 Action Plan: Team will sit on alarms and solicit feedback.

Webinar 3 Action Plan: Education will be provided to staff, and families related to alarm usage and posting information for review about replacing alarms with better practices.

Webinar 4 Action Plan: Education for staff on 4 Ps and an E and proactively checking in with residents.

Webinar 5 Action Plan: DON choosing to brainstorm each resident regarding individualized engagement and then reach out to wider team.

Webinar 6 Action Plan: Webinar is very informational, sad that COVID has us on such lockdown restrictions that thinking of outdoor excursions seems like a thing of the past for the moment. Majority of staff is consumed with care or diffusing/deescalating of behaviors.

Webinar 7 Action Plan: Alarms not in use except for short term change in condition. For example, 3-day, 7 day or 14 day needs for change in condition. Will pursue more detail on each resident’s care plan regarding music, outdoors and lavender essential oil use.

Webinar 8 Action Plan: Starting to discuss individual sleep patterns including incontinence/bathroom needs in order to honor and give more hours of restorative sleep.

Webinar 9 Action Plan: MDS coordinator will take lead in identifying on each resident’s care plan what people need for a good night’s sleep and highest practicable level of physical, mental and psychosocial wellbeing.

Webinar 10 Action Plan: ED will bring to team to start discussing each resident's domains of wellbeing and with MDS Coordinator to get on care plans and share white paper with activity director.

Webinar 11 Action Plan: Marshall was asked numerous times and just couldn't pull it off with so many staffing shortages, changes and even sickness

Webinar 12 Action Plan: **Any idea from a fellow team in the project**: Incorporate more activities throughout the day, focusing on people who fall a lot. **Action plan into the future:** Continue individualizing care plans detailed to the nature of the fall.

Medical director involved during monthly QAPI meetings. Competencies in QA meetings, staff in-services and education. Education shared with wider team at all-staff meetings. Success story: 2nd quarter - DON brainstormed on her own engagement ideas for each resident, even before she goes to activity team. 3rd quarter – were down to 1 alarm, one new resident with TBI needing an alarm so up again to 2 and this one person had 11 falls of the 25 so it would otherwise be 14 falls. And alarms down from original 10. Lots of changes in staffing but still proceeding with ideas from this project. 4th: Have new view that not every fall is the same. And approaches should be individualized to the person and the nature of the fall.

| **Oaktree** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 4 | 4 | 4 | 5 | 5 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 4 | 4 | 4 | 5 | 5 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 7 | 14 | 6 | 11 | 1 | 4 | 6 | 5 | 3 | 5 | 4 | 16 | 12 |
| Fall w/ injury | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |

**Consulate Health Care at Oaktree**

Contact: Elise Hechinger-Johnson, Executive Director

650 Reed Canal Road South Daytona, FL 32119 386-767-4831

Webinar 1 Action Plan: We had staff to sit on the alarms during a meeting so they could see how the residents felt.

Webinar 2 Action Plan: Educate staff on how alarms can be scary for a confused resident.

Webinar 3 Action Plan: Teatime every 2 hours announced turn and offer water and ask if anything residents need.

Webinar 4 Action Plan: Educate staff on how alarms can be scary for a confused resident.

Webinar 5 Action Plan: Elise to ask therapy for different times of day. Mini audit of residents re: timing. Try calendars and books with photos. Post 4 Ps and an E in every resident room.

Webinar 6 Action Plan: Restore restorative services, have had a gap, now holding people accountable. Conducting a mini audit regarding timing of restorative/therapy services for residents. Using an exercise video on TV.

Webinar 7 Action Plan: We have started giving more permanent assignments and involving direct care team members in giving input on ideas for preventing falls per resident.

Webinar 8 Action Plan: Start talking with team and 3rd party about open dining.

Webinar 9 Action Plan: Met with the staff to encourage the residents to do as much as they can with their ADLs instead of just doing things for them.

Webinar 10 Action Plan: Resident jobs, some residents want a job.

Webinar 11 Action Plan: Every other week, I (the ED!) am going to ask a resident what would make their day. (Wow. So impressive.)

Webinar 12 Action Plan: Continue to keep alarms out of the building.

Medical director involved during QAPI monthly. Competencies taught in weekly training with nursing, monthly all staff education. Information shared with the larger team during education as well as emails.

Success stories: 2nd quarter - Only one fall in the whole month of November! This is a record. Why? Being more active, getting residents to the bathroom more often, CNAs active and proactive, checking in with residents. Also there used to be a room where CNAs would hang out, but it has been made into an office and we see CNAs out and with residents more now. Also, nurses being proactive and stating often to "keep an eye on" residents. 3rd quarter – got to and have remained at zero alarms! Falls still very low. Increase in helping residents to get outside. 4th: The ED personally is going to ask a resident what would make their day. Shared Second Wind Dreams and the idea of a dream committee with her.

| **Rio Pinar** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 30 | 30 | 25 | 25 | 15 | 10 | 10 | 10 | 10 | 10 | 10 | 0 | 0 |
| Residents with alarms | 30 | 30 | 25 | 25 | 15 | 10 | 10 | 10 | 10 | 10 | 10 | 0 | 0 |

| Falls | 43 | 28 | 29 | 49 | 36 | 40 | 39 | 38 | 37 | 35 | 28 | 22 | 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fall w/ injury | 1 | 1 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

**Rio Pinar Health Care**

Contact: Devon Palmer, ED

7950 Lake Underhill Rd., Orlando, FL 32822 407-658-2046

Webinar 1 Action Plan: Developed a QAPI fall action plan.

Webinar 2 Action Plan: Will have staff members sit on alarms in next meetings for sensitivity training, Lionel, ADCS to lead.

Webinar 3 Action Plan: Teach and post the 4 Ps and an E and formalize times for team members to assist certain residents to the restroom.

Webinar 4 Action Plan: Team was unable due to COVID.

Webinar 5 Action Plan: Provide education to staff and residents. Individual and ability. During care conf.

Webinar 6 Action Plan: Continue reducing alarms by implementing frequent checking and addressing all resident needs. Activities is being offered as diversional and more encouraging due to our Hispanic population.

Webinar 7 Action Plan: Started with individualizing for one resident and in her care, plan approaches to use music and how, and to go outside and when. These really help to calm her anxiety. Also coached to use proactively not only reactively.

Webinar 8 Action Plan: Had planned but were just unable with many staffing challenges. Since then, now have a new risk manager in leadership of this project and taking it very seriously. See below.

Webinar 9 Action Plan: Team will watch webinars. Will post 4 Ps and an E around building and in res. rooms. Identify how to increase movement on each resident's care plans. Remind all team members to ask proactive questions, look for residents and families and volunteers.

Webinar 10 Action Plan: Remove all alarms and replace with frequent checks. Pro-active with resident's needs. Removed all alarms and replaced with Q 1 hour frequent checks.

Webinar 11 Action Plan: Managers daily rounds in am, not 100% effective, continue educating managers to observe and identify possible factors that can contribute to a fall. Examples: clutter, equipment not in use and still left in room, slippery floors status post wax, bed side commode not in use, etc.

Webinar 12 Action Plan: Anticipating resident needs.

Medical Director involved during monthly QAPI meetings, return demonstrations for competencies and information shared with wider team during Town Hall all-staff meetings.

Success story: 2nd qtr. - During a tough time of COVID, activity director Luz has gone above and beyond by opening windows, brushing hair and trying to do just a little bit more for residents. 3rd qtr. – Have had a hard quarter with many staff leaving for other jobs but remain committed. New risk manager in leadership of this project along with ADON very excited. Will get team members caught up with watching webinars. Alarms and falls are down so that feels good. 4th qtr: Did have trouble educating, found alarms hidden, finally realized had to throw alarms away. Did get to ZERO alarms. One approach implemented is 30 min. checks for 72 hours. Offering increased movement with Fun and Exercise Days. Pro-active with resident's needs: 1 hour frequent checks with "Hall Monitors" – working on title, i.e., Neighborhood Companion. "The more often you go, the less needs they have." During the tough time of COVID, activity director went above and beyond by opening windows, brushing hair and trying to do just a little bit more for residents, even haircuts!

| **San Jose** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 6 | 6 | 5 | 5 | 5 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 6 | 6 | 5 | 5 | 5 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 41 | 9 | 9 | 19 | 24 | 19 | 13 | 12 | 6 | 9 | 14 | 13 | 4 |
| Fall w/ injury | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |

**San Jose Health and Rehabilitation Center**

Contact: Shonda Taylor, ED

9355 San Jose Blvd, Jacksonville, FL 32257 904-739-0877

Webinar 1 Action Plan: Will try playing 15 min. chunks of webinar for staff training.

Webinar 2 Action Plan: Involving all staff regarding potential deficient practices regarding falls – specifically residents rights. Also, identified and spoke with family member partners to continue discussion regarding everyday habits of the residents prior to becoming

residents (as appropriate) over telephone and zoom, which are much appreciated by family and staff.

Webinar 3 Action Plan: Involving the IDT and family in efforts to anticipate the needs of our residents. We are communicating via group huddles and calling engaged family members in developing a plan that will help us be proactive.

Webinar 4 Action Plan: Continue to involve the IDT in efforts to anticipate the needs of our residents. We are communicating via group huddles and calling engaged family members to continue gathering their feedback in developing a plan that will help us be proactive.

Webinar 5 Action Plan: Continuation of anticipation of needs, family & CNA involvement, and creative ways to engage residents. Continuing to investigate what the person's career, hobbies, or interests were, prior to living in the center. With this information, we are able to work towards more engaging activities.

Webinar 6 Action Plan: Continue with anticipation of needs. Now we will shift and incorporate mobility. We also believe that the "Benefits of Mobility Far outweigh the risk of falling." The team is doing an awesome job with anticipation of needs and having fun while working towards staying ahead of needs.

Webinar 7 Action Plan: Continue to anticipate the needs of the people who live in our community and try innovative ways to engage our people. We continue to engage families, safety.

Webinar 8 Action Plan: Continue above plan. We all found Webinar #8 to be uniquely personal because we all identified with the need for honoring sleep, in our personal lives. We are adding "Honoring Sleep" considerations in all that we do for the people who live in our home. In that, we are looking at a more liberalized med pass, food service accommodations and special events/functions.

Webinar 9 Action Plan: Continuation of anticipation of needs and incorporate 4 Ps and an E.
Webinar 10 Action Plan: Continuing prior plans: Anticipation of needs for the entire home and 4 Ps and an E reminders and actions to reduce falls. Will start roundtable discussions of seven domains of wellbeing in various meetings i.e. huddles, resident council, town hall, care conference, etc.

Webinar 11 Action Plan: Continue anticipating needs, 4 Ps and an E, and honoring sleep

Webinar 12 Action Plan: Continue to anticipate needs, implement 4 Ps and an E, and honor sleep.

Medical director has been excited about our progress and we continue to engage him via Ad hoc QAPI. Incorporation of best practices learned into competency-based education to enhance sustainability and regulatory compliance via QAPI, grand rounds, and small group huddles.

Success story: 2nd quarter - Have hired some great talent as PCAs and are on track to become CNAs. It has been a team effort to learn and create a culture desperately less about alarms and more about anticipation. Thinking outside the box, motivated and engaged in different things and supporting residents to be "free to roam about the cabin." Including housekeepers and laundry. Involving the families more, full transparency, used to be we didn't want them to have a peek behind the veil and better anticipate and feel a part. On resident was former housekeeper and they realized she needed to move and help around mealtimes. of course. Another was a former teacher and then realized she needed to move about and help as if in a classroom, of course. 3rd qtr. – The most dramatic statistics are from this home with a high of 44 falls and now a low of 6 falls end of March. Asked ED why? We recognize how good this series is and what we've learned from it/you. We involve more people in the statistics and creating approaches, the IDT as a whole, feedback from families about a person's career, habits. Then anticipate needs, strongest aspect. Inquiring more. Asking more questions. Picking up on cues for hunger, bathroom, pain, communicate to nurse proactively instead of after a fall. Increased communication. 4th: Anticipate" sums the project up not just for bathroom needs and not just for ADLs but for all of a person, those personal needs, the Chapstick, careers as well as the 4 Ps and an E was instrumental.

Used to have a Fall Focus Room with activities and to "keep a closer eye on" those at risk for falling. We realized our focus was to get all those falling together and provide the same amount of stimulation but for some that was too much stimulation. Realized actually closing that area was a benefit. Along with our changed approach, we had an epiphany that a group cannot be all to all people ever. A person that lived here once said "I don't want to go to the Fall Focus Room. You go there to be punished if you fall so, we had changed the name to Starlight Lounge and offered more activities, but the pandemic took us to the next level of awareness. If the room has such a negative connotation and it's not individualized, we need to go after what motivates a person to move, individually and no longer have the institutional fall focus group.

| **Governor's Creek** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Residents with alarms | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Falls | 11 | 6 | 14 | 17 | 11 | 11 | 12 | 9 | 6 | 10 | 9 | 12 | 15 |
| Fall w/ injury | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |

**Governor’s Creek Health and Rehab**

Contact: Gregory Forbes, Executive Director

803 Oak St., Green Cove Springs, FL 32043 904-284-5606

Webinar 1 Action Plan: Build rapport with family insisting on alarm, get to know resident and needs better. Play 15 min. rotating chunks of webinar for all staff coming and going during COVID testing day.

Webinar 2 Action Plan: Creating individualized fall approaches that are resident specific.

Webinar 3 Action Plan: Idea to do scheduled checking in and talk to staff and ask for greatest needs and times of need.

Webinar 4 Action Plan: With new Director of Clinical Services, reimplement processes that had fallen by the wayside, full IDT initiative, revamped checking in tool to be more specific looking at fingernails, clipped, urinal, etc. We ask each resident their concerns or grievances to be more proactive about it instead of letting it fester.

Webinar 5 Action Plan: Reimplemented clinical meeting to be proactive.

Webinar 6 Action Plan: Been thinking about grab bars. Kaley suggested adding to the A bed side of some rooms increasing independence in getting to bathrooms, also post 4 Ps and an E and refocus on that and ask each manager for a list of tasks for jobs for residents who want them.

Webinar 7 Action Plan: Music - partnered with Women’s Empowerment Services and got seven iPads for music with a radio feature called “Radio App” any type of music of any decade in any country of the world.

Webinar 8 Action Plan: Will start talking to dining team, lab company to open dining and lab draw times in order to support sleep.

Webinar 9 Action Plan: Community engagement, try asking resident, family and team to define highest practicable level of physical, mental and psychosocial wellbeing of each resident. Will post in rooms the 4 Ps and an E.
Webinar 10 Action Plan: Start to talk about with team and residents, Resident Council and team meetings, start care conferences too. Seven domains of wellbeing. Maybe pick one each quarterly conference.

Webinar 11 Action Plan: Give questions to residents prior to care conference. Report card idea.

Webinar 12 Action Plan: Covid hit, will try to keep incorporating all of the above.

Medical director involved at monthly QAPI. All staff taught at monthly town hall meetings, monthly nurses and CNA meetings, ad hoc educational opportunities.
Success story: 2nd qtr. - Governor's Creek Voted one of the Great Places to Work. Celebrate and contribute to the community, inviting team members to be more involved walk to the park, include all residents, more movement, engagement, etc. 3rd qtr. – Social worker will talk to several residents about checking in with one another, many seek a purpose so this idea might go far. 4th qtr: "Biggest take away was consistent staffing. Takes stress off team when you know what to expect."

| **Lake Mary** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 35 | 40 | 35 | 32 | 41 | 44 | 21 | 16 | 9 | 5 | 0 | 0 | 0 |
| Residents with alarms | 35 | 40 | 35 | 32 | 41 | 44 | 21 | 16 | 9 | 5 | 0 | 0 | 0 |
| Falls | 49 | 47 | 26 | 33 | 36 | 33 | 40 | 35 | 14 | 26 | 24 | 25 | 25 |
| Fall w/ injury | 0 | 2 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Lake Mary Health and Rehabilitation Center**

Contact: Larry Mann, ED

710 N. Sun Dr, Lake Mary, FL 32746 407-805-3131

Webinar 1 Action Plan: Activities will evaluate what interests residents so they are not bored.

Webinar 2 Action Plan: Team members sat on alarms Oct. 2. Responses were negative: too bulky, too loud, uncomfortable and they felt like they did something wrong when the alarm went off.

Webinar 3 Action Plan: Team is asking families for more information regarding resident interests and activities is providing more such as folding, ball toss, baseball with the noodles, color by number.

Webinar 4 Action Plan: Proactively rounding and ask if resident would like to go to the bathroom without them putting on the light. Discussing the reeducation of fall alarms

Webinar 5 Action Plan: Falling star program where there is a star on the door and the chart of low-risk resident instead of an alarm and frequently checked on to anticipate their needs.

Webinar 6 Action Plan: 4Ps/E posters in most areas but will add to all rooms, staff education, more interactive items- clocks, calendar, books, pics, magazines.

Webinar 7 Action Plan: Working with activities team. More outdoor activities, live music, animal visits, spa days, more reading materials, old pictures of residents, getting family more involved. Anticipation of needs is helping a lot as well as more involvement in activities with the activities team.

Webinar 8 Action Plan: Honor sleep and open dining. Do not wake residents. Honor the resident right to choose schedule for activities and dining and therapy. These practices will help residents heal better, be happier, rested and content.

Webinar 9 Action Plan: Practicable instead of practical. Based on individual's abilities, limits and potential. We want the highest level of function, well-being and quality of life. Action plan for the three well-beings:

- Physical- Implement healthier eating, exercise or restorative programs, more outside time.
- Mental- More activities, more communication, listening and support for residents (resident council meeting).
- Psychosocial- More family involvement (weekly calls), spiritual and social gatherings (church services).

Webinar 10 Action Plan: The Eden Alternative Domains of Wellbeing Action plan-
Helping residents with overall wellbeing. Meeting monthly at resident council. Asking for resident and family expectations. Connectedness with family, friends and other resident in activities and outings. Making residents feel like they have purpose and meaning. Getting family more involved. Old photos, books, magazines and or history of resident.

Webinar 11 Action Plan: Focus on: alternative approaches to include but not limited to increased activities and "therapies."

Webinar 12: Action plan into the future: The action plan for the future is to continue our daily falls review with appropriate interventions, review weekly falls trending in our SOC meeting, and monthly review of falls in our QAPI.  If any trends are identified, we will implement a four point plan to address and improve outcomes.

Medical Director is involved during monthly QAPI meetings.  Competencies are sustained via audits and new practice information is disseminated during monthly trainings

Success story: 2nd qtr. - Third shift is anticipating bathroom needs; team is checking on residents more frequently and has seen fewer falls during that timeframe. 3rd qtr. – Alarms

down to 5! And falls have decreased. Stopped using the process that if a resident had a certain score, then an alarm was used and instead doing a deep dive into the person, talking to family, more individualized approaches. "We were just used to using them but that doesn't necessarily mean they were working.

| **Bradenton** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 4 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 7 | 19 | 15 | 20 | 20 | 13 | 17 | 15 | 22 | 19 | 9 | 9 | 12 |
| Fall w/ injury | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 1 |

**Bradenton Health Care**

Contact: Jennifer Davis, MDS Coordinator

6305 Cortez Rd. W., Bradenton, FL 34210 941-761-3499

Webinar 1 Action Plan: Have team members sit on an alarm at an upcoming meeting. Webinar 2 Action Plan: We will try to become an alarm free home by teaching our staff the necessary better practices to do so. We will do this by offering in-services and education during our town halls and our mandatory in-service education times.

Webinar 3 Action Plan: At the beginning of the month, we became alarm free (October). We will continue to educate staff that care plans need to be individualized as well as ones that anticipate needs especially ones for going to the bathroom. We will also be doing call audits to help with anticipating one's needs, and this will give us something to measure how well anticipating needs works with not only call lights but falls as well.

Webinar 4 Action Plan: Our action plan is to have all our staff learn the 4P's and an E and to implementing to see if we notice a fall reduction by using these questions to be proactive of the resident's needs.

Webinar 5 Action Plan: Need more staff engagement, communal activities, when allowed, and anticipate needs.

Webinar 6 Action Plan: To train staff of all disciplines to watch for q's from residents needing to move and that no matter what your position you can walk with a resident. Also, we have encouraged all staff to let us know if they feel a resident may not need a wheelchair or will benefit from therapy. Activities has added radios to all nursing stations for music.

Webinar 7 Action Plan: Renovation in memory care starting courtyard not utilized by residents when new maintenance director comes mid-March will view options. Door is with a keypad. Also tents outside middle of courtyard will use for outside and sit in shade too. Increase music individualized and in care plans and outcomes.

Webinar 8 Action Plan: Two residents have asked specifically not to be bothered or woken. Discussing with residents about sleep during their welcome meeting.

Webinar 9 Action Plan: Care planning physical wellbeing, to actually use the restroom as it is so much better overall involving walking, is more dignified, range of motion, etc.

Webinar 10 Action Plan: Eden Alt seven domains of wellbeing in resident council, and care conferences.

Webinar 11 Action Plan: MDS coordinator to watch the recording and ask to take the lead on getting practices on each resident's care plan.

Webinar 12 Action Plan: Our action plan into the future will be to continue offering a homelike environment that is alarm-free. Person-center care plans and continue training/educating our staff on anticipating our residents' needs. Coming up with creative, innovate and personalized methods to prevent falls.

Medical director is involved in monthly QAPI and informed with calls, handout, and email. Competency-based education via in-services and yearly check-ups as well as on-the-spot questions of what the P's and E mean and when you are supposed to be asking these questions. Information will be shared with larger team through weekly town hall meetings where we educate our team members about new and better practices as well as in-services and group huddles.

Success story: 2nd qtr. - Still at zero alarms. CNAs, nurses, restorative walking with residents more. Therapy screeking all residents for baseline following pandemic and to ascertain if a person needs wheelchair or not. To help residents move more: administrator will help a resident move when he answers a call light, activity director is committed to getting residents outside more and the DON blows kisses to get residents moving more. 3rd qtr. – Jennifer Davis, DON, is so astute with her observations we are trying to capture them. By taking a person to the bathroom, it is so much better as she always states. We are working on an acronym to depict this. Maybe DIGNITY or ABLE. We want to highlight words such as: dignity, more effective, better, restroom, walk, range of motion, movement, flexible, cost effective, proactive, highest practicable, … everything. 4th qtr: Everyone can help to improve range of motion. Focused on being proactive. DON Jennifer Davis also wisely points out: "If we anticipate needs, will be less call lights total. NOT taking a person to the bathroom takes DOUBLE the time. Incontinency with all the work regarding clean up takes DOUBLE the time.

Helping a person to the bathroom takes HALF the time. You can save time! Hard to have a BM in bed or w/c, devastated. Body reacts more naturally, let alone more dignified.”

| **Pensacola** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 9 | 14 | 20 | 12 | 12 | 18 | 5 | 14 | 12 | 9 | 11 | 7 | 12 |
| Fall w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Consulate Health Care of Pensacola**

Contact: Shalonda Martin, DON

235 W. Airport Blvd, Pensacola, FL 32505

Webinar 1 Action Plan: Will continue to decrease the availability and use of alarms as approaches for residents who fall.

Webinar 2 Action Plan: Will remain free of alarm use and remove the option to place an alarm after a resident falls.

Webinar 3 Action Plan: Will remain free of alarm use and remove the option to place an alarm as an intervention after a resident falls. Anticipate the resident’s needs. Communicating with current residents /family members that have an increase in falls to discuss approaches in hopes to anticipate the resident’s needs and reduce falls.

Webinar 4 Action Plan: We will remain free of alarm use and remove the option to place an alarm after a resident falls. Proactively Checking in with Residents: Educate staff while interacting with the residents to utilize The Four P’s and an E: Are you in pain? Do you need anything including the bathroom? Are you comfortable with your positioning? Do you haven everything around you that you need? Engagement: Question to engage resident. Example: Do you want to look at another scrapbook today? I can get it off the shelf.

Webinar 5 Action Plan: All residents have a need for engagement in meaningful activities. The lack of engaging activities can cause boredom, loneliness, and frustration, resulting in distress and agitation. The activities director and activities assistant will interview residents and family members regarding meaningful engagement activities. An individualized care plan and activities program will be developed to meet the needs of the resident. All staff will participate in engagement activities with the residents. This can also help prevent and reduce falls.

Webinar 6 Action Plan: Facility will remain free of alarm use and remove the option to place an alarm as an intervention after a resident falls. 75% of the resident utilize wheelchairs however 1-10 residents could be supported to not use the wheelchair anymore. For the residents identified, the therapy department will eval those residents and develop a restorative nursing plan as appropriate. The activities department will engage residents to participate in mobility activities such as doorway exercises, walking visit, and outdoor activities.

Webinar 7 Action Plan: Facility will work on implementing consistent/dedicated support. The nursing team will evaluate staff assignments to ensure consistent staff who are more familiar with the resident provides care on a routine basis. This will also help identify changes in a resident's condition and behavior which in return will help decrease falls.

Webinar 8 Action Plan: Team will interview residents regarding their preferred sleeping regimen. Based on the information expressed during the interview the interdisciplinary team will work with the resident to develop a plan that is acceptable for their desired preference in hopes to support sleep needs and support better outcomes.

Webinar 9 Action Plan: Staff will begin to implement the engagement boxes for the resident with items that bring the resident comfort and familiarity. This could be used when the resident is feeling depressed, anxious, overwhelmed, frustrated, etc. The use of the engagement box could also help decrease depression, falls, anxiety, etc.

Webinar 10 Action Plan: Educate staff and residents regarding implementing the domain of wellbeing into our culture. The domain of well-being will be discussed during activities, resident council meetings, morning meeting, etc. This team is very interested in becoming an Eden Alternative registered home and in implementing the seven domains of wellbeing intentionally.

Webinar 11 Action Plan: Revamp individualized care plan process. Reschedule care plan meetings for all the residents in the building (starting with the residents that have had prior falls.) The goal is to obtain additional information that can help the staff get to know the resident better and provide services to meet the resident's needs. Information gathered will be the residents preferred daily routine, daily pleasures, passions, etc.
Webinar 12 Action Plan: Continue to follow prior actions plan initiated by the facility We are still in the process of rescheduling care plan meetings for all the residents in the building (starting with the residents that have had prior falls.) The goal is to obtain additional information that can help the staff get to know the resident better and provide services to meet the resident's needs. Information gathered will be the residents preferred daily routine, daily pleasures, passions, etc. We are also going to implement getting additional information

for new/short term residents during our journey home meeting that can help the staff get to know the resident better and provide services to meet the needs of the resident's needs.

Information reviewed with medical director during monthly QAPI meeting and invited to webinars. Competency-based education via continuing to encourage staff participation in the process of becoming an alarm free home and encourage staff to voice ideas of alternatives to alarms. Will continue to provide information to wider all staff in small group meetings to maintain social distancing.

Success story: 2nd qtr. - Administrator making a point to tell staff particularly agency staff to call her with any questions as they know residents best. Also, targeted observations, making sure helping residents to bathroom at intervals, more aware, more personal, staff on board with this new approach. Also talking about all this at town hall meetings monthly with team members. 3rd qtr. – Did assessment screenings and as predicted, four residents did not need their wheelchairs and no longer using. From the webinars are realizing how "nursing homes are institutionalized, need to put ourselves in their shoes, we are not doing what the resident wants because it is all about us. Have posed that one resident "doesn't like the food." No, he just doesn't want to get up, he wants to sleep and start his day at 10 am. Are working into an interview now to ask residents preferences for waking and sleeping and what need for a good night's sleep. 4th qtr: This team interested in becoming an Eden Alternative registered home and pursuing the seven domains of wellbeing, very exciting.

Used quotes from leaders at Pensacola in final webinar:

"Alarms don't do anything. An alarm is just one more thing you can say you did. Alarms make it look like you've addressed the problem of falls, but it doesn't really address anything. We're not looking at why someone is falling. We get used to the routine and used alarms by rote" stated by Shalonda Morton, ED CHC Pensacola.

"Alarms give it away that I need help and are humiliating because it felt like I couldn't do anything. No independence, had to wait for someone. Everyone will know I need help; don't want to admit need help. Leads to depression; you just sit there. When nobody comes, you do it yourself and fall" stated by Jeannie Evans MDS Coor. CHC Pensacola.

| **Rosewood** | Jul 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 28 | 16 | 9 | 9 | 7 | 7 | 4 | 4 | 4 | 4 | 2 | 0 | 0 |
| Residents with alarms | 28 | 16 | 9 | 9 | 7 | 7 | 4 | 4 | 4 | 4 | 2 | 0 | 0 |
| Falls | 14 | 17 | 14 | 14 | 11 | 17 | 11 | 10 | 11 | 12 | 14 | 11 | 15 |
| Fall w/ injury | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |

**Rosewood Health and Rehabilitation Center**

Contact: James Clemons, Executive Director

3920 Rosewood Way, Orlando, FL 32808 407-298-9335

Webinar 1 Action Plan: Reduced the number of alarms used by the end of the month, redirecting triggers and risk factors such as noise, more rounding with staff.

Webinar 2 Action Plan: Better assessment and more frequent checking in with resident.

Webinar 3 Action Plan: Individualized bathroom schedule.

Webinar 4 Action Plan: Proactive visits with residents.

Webinar 5 Action Plan: More individualized activities.

Webinar 6 Action Plan: Staff education and move residents who fall frequently close to the nurse's station, frequent checking in with residents.

Webinar 7 Action Plan: Daily checks of resident's alarms.

Webinar 8 Action Plan: Continue elimination of Wanderguard.

Webinar 9 Action Plan: This month we are going to use an individualized approach. Use resident goals to create a plan. Create volunteer jobs. We are also looking to partner again with the pre-school across the street once covid decreases.

Webinar 10 Action Plan: Re-education.

Webinar 11 Action Plan: Review care plans and make sure they are resident center and directed. Ask the resident and family questions. Review preferences.

Webinar 12 Action Plan: Continue to gather as much information about the resident prior to admission and create care plans that are more resident-centered.

Medical Director is very involved participating in these calls and educational videos. We talk almost on a daily basis. Ongoing education particularly in weekly team meetings.
Success story: 2nd qtr. - Administrator offered to assist with exercise class, unit manager to assist with restorative, activity director to provide nail care, wash hands, apply lotion and thereby range of motion and DON to assist with ROM when with residents who need it to increase movement for residents. 3rd qtr. – Down to only 4 alarms from 28. When asked how:

"We are trying to use all the avenues learned in this project, instead of an alarm, let's look at all the other scenarios Miss Carmen taught us." 4th qtr – Down to 2 alarms early June and zero by end of the project. Did it with a lot of family involvement. Have a new attitude to just not jump to alarms but do better assessing instead. Dug deep into root cause and increased observing, lots of education to everyone as everyone is our eyes and ears no matter their role. From Ann Barlow Unit Manager, "Taking a person to the bathroom is a lot easier. I think the younger generation needs reminded that it is better for everyone to get to sit on the toilet. More dignified."

| **Coral Trace** | Jul. 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | Jun. 21 | Jul. 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 4 | 3 | 2 | 2 | 2 | 1 | 3 | 5 | 2 | 0 | 0 | 0 | 0 |
| Residents with alarms | 4 | 3 | 2 | 2 | 2 | 1 | 3 | 3 | 2 | 0 | 0 | 0 | 0 |
| Falls | 24 | 29 | 30 | 33 | 32 | 25 | 21 | 24 | 25 | 34 | 30 | 20 | 21 |
| Fall w/ injury | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

Decreased Numbers of Falls Aug. 2020: 0 Decreased Numbers of Falls July 2021: 4

**Coral Trace Health Care**

Contact: Shelly Grimes, ED

216 Santa Barbara Blvd, Cape Coral, FL 33991

Webinar 1 Action Plan: Scheduling activities for residents who are falling several times a week.

Webinar 2 Action Plan: Change terminology in community to make it more resident centered.

Webinar 3 Action Plan: Fall focus group with activities daily, workstations in activity room, fall boxes with activities, proactive with new resident with fall scores above 50, education on psychosocial to provide activities reduce falls without alarms, introduce the 4 p's and an E.

Webinar 4 Action Plan: Education for staff and residents and being proactive with residents who are at risk for falls.

Webinar 5 Action Plan: Very impressed with the 4 P's and E. Will roll that out next week.

Webinar 6 Action Plan: This month is on mobility. I will request the activities do more with music and movement and best we can and stay in compliance with the CDC guidelines. I have also started education on walking people to their bathrooms instead of taking them in their chair, this education is also including when people continue to stand, they have a need that

has not yet been met. Even if it is just to stand and move around. As of right now any new residents are to be in quarantine for the first 14 days, so this is difficult.

Webinar 7 Action Plan: Name group that gathers for falls group an inspiring and alluring name. “The Rising Graduates”. Meet with group on regular basis. Continue with balance, core and kinesthetic exercise and reinforce need for calling to go to bathroom and wear shoes. Call brother of resident with most falls and ask for tablet and CD/radio r/t his original likes on psychosocial. Order a book on dogs and one on Pennsylvania.

Webinar 8 Action Plan: This month is on dining and sleep preferences. I will monitor the sleep/wake times and advise department heads of any issues. I have also started education on eating and sleeping preferences. Bedtimes and waking residents are done according to their preferences. I do observation audits in the morning and check with residents on whether their preferences are being met. Dining is now open for lunch. A survey was taken and those wanting to attend are brought to the dining room. Those who decline to go are honored.

Webinar 9 Action Plan: Brainstorming on ideas for purposeful activities, such as knitting caps for newborns and socks for the shelters and wrapping sandwiches for the shelters. Discuss with Nurse Supervisors and department heads about honoring the highest practicable level for the residents to do. Do In service with CNA’s for follow up. Audit through observation and on the spot training. Check on residents “What is your goal on how you want to spend the day?” “I” care planning in care plans.

Terminology in community is more resident centered. “The Rising Graduates”, meeting with group on regular basis. All at risk residents are encouraged to attend meetings and activities. All staff aware, interventions discussed and utilized. Ongoing education at falls meeting, clinical meeting and during day. In service on PPPPE’s, relaying info to team, reminding as necessary, posting PPPPE info in employee areas.

Webinar 10 Action Plan: Continue with community projects of newborn hats/welcome bags, look into foster dogs, birds or fish. Recruit new resident for garden watering/check. Resume Catholic communion. Begin musician visits.

Webinar 11 Action Plan: Continue with actively engaging residents, rounding and anticipating resident’s needs.

Webinar 12 Action Plan: Continue to implement the 4 P’s & E. Implement specific person centered language into care plans & daily language.

Success story: CNAs more engaged, are asking the 4 Ps and an E, walking more than sitting down. Activity director took it upon herself to create a special group to focus on gaining

strength and education about preventing falls. 4th qtr: deeper dive now getting to know residents better; success story Daniel – increased learning of the person as an individual with a focus on engagement; discovered he, loves the Bee Gees, engagement, contacted brother who helped, brought CDs of Bee Gees and more, CD player, bought a book with beautiful pictures of Pennsylvania where he was born and he enjoys it, also a Tablet and books about history which he loves, focused on preventing falls *with* him, got better shoes, etc.; increased engagement: garden, chrysalis.

| **Orange Park** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 25 | 10 | 13 | 8 | 17 | 19 | 26 | 14 | 16 | 13 | 10 | 17 | 27 |
| Fall w/ injury | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |

**Consulate Health Care of Orange Park**

Contact: Gregory Forbes, ED

1215 Kingsley Ave., Orange Park, FL 32073 904-269-8922

Webinar 1 Action Plan: Webinar 1 and 2 watched by team by next Wed.

Webinar 2 Action Plan: Talk about turning off the call light noise and use light only which is allowed per CMS regs. Start to talk with team.

Webinar 3 Action Plan: 1) Residents could benefit from webinars their growth and development, and 2) changing our terminology to be less institutional.

Webinar 4 Action Plan: We will encourage staff to be more proactive and ask residents if they need to go to the bathroom and if they need to repositioned. Continue working on the power of language – educate department heads and educated staff during monthly town hall meetings.

Webinar 5 Action Plan: Invite families via letter to participate in the next webinar.

Webinar 6 Action Plan: Do at least 2 activities outside a month, research GROW Program at thegrowprogram.net.

Webinar 7 Action Plan: Look into grab bars for resident rooms and research the Getting Residents out of Wheelchairs.

Webinar 8 Action Plan: Invite residents to April webinar and promote foods/snacks that residents like.

Webinar 9 Action Plan: Follow up on any action plans not done.

Webinar 10 Action Plan: The major focus is on autonomy. We are empowering the residents to help solve issues that arise and to be solution oriented. It is ultimately up to the residents of the home to help make this place as happy and successful as possible. Resident council will no longer be a problem focused arena but a solution focused discussion.

Webinar 11 Action Plan: Regarding life and wellbeing, team is supporting residents to have 9 cats in courtyard, neutered and spayed, shots and feeding them, lots of life and purpose. Also tasked with what are we going to do to further culture change? We are going to liberalize diets and change language and take down unnecessary signs and remain "units" to neighborhoods. "Thank you for hosting the project, we really appreciate it."

Webinar 12 Action Plan: Continue to focus on employee retention as a part of our permanent assignments so that residents and employees know each other's routines.

Medical Director very involved creating ideas and helping with daily rounds and providing on the spot education with observations.

Competency based education via small group meetings, clinicals, stand up. Information with the wider team will be shared monthly town meetings. After webinar mention preventing falls webinar to wider team.

Success story: 2nd qtr. - Trying an idea shared by Consulate to give residents a door hanger that states "Activity Please" to give them the ability to ask for more to do. 3rd qtr. – Expanding list of volunteer opportunities for residents. One is very talented artistically and will ask her if she is interested in doing or helping with bulletin boards monthly. 4th qtr: A focus on changing institutional culture with residents as decision makers, change in language and life in the courtyard with nine cats!

| **University Hills** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 7 | 15 | 7 | 7 | 9 | 8 | 8 | 5 | 4 | 4 | 4 | 4 | 1 |
| Residents with alarms | 7 | 15 | 7 | 7 | 9 | 8 | 7 | 5 | 4 | 4 | 4 | 4 | 1 |
| Falls | 4 | 14 | 13 | 19 | 23 | 8 | 21 | 30 | 17 | 25 | 15 | 20 | 18 |
| Fall w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |

**University Hills Health and Rehabilitation**

Contact: Tammilyn Vinson, Executive Director

10040 Hillview Rd, Pensacola, FL 32514 850-474-0570

Webinar 1 Action Plan: Review the residents with alarms and identify alternatives that can be put into place once alarms are removed.

Webinar 2 Action Plan: Set up a 3-round process of those individuals that have alarms and identify the which residents can have an alarm removed in the 1st, 2nd and then 3rd round.

Webinar 3 Action Plan: Post the 4 Ps and an E sign/poster around the building.

Webinar 4 Action Plan: Post and share and teach the 4 Ps and an E, add to customer service, adopt a resident daily check to ensure they have all the things they need so not in and out all day.

Webinar 5 Action Plan: Focus had to be on an outbreak of COVID.

Webinar 6 Action Plan: Will share with new activity director link to Engagement webinar and invite her to consider more engagement items in resident rooms.

Webinar 7 Action Plan: No action plans this month, dealing with another COVID outbreak.

Webinar 8 Action Plan: Continue to focus on 1:1 type activities and identifying resident interests. Action plans are on-going, progress made is then COVID outbreaks happen and it's like starting over once the outbreak is over.

Webinar 9 Action Plan: Help residents get reacclimated to moving around, going on outings, and resident education on how to safely transition back into things returning to normal. Continue to build on old concepts and revisit ones that are not as successful as they were initially and/or revise concepts as needed to meet the needs of the residents.

Webinar 10 Action Plan: Stay the course and work on resident education for safety while walking, transferring, and repositioning.

Webinar 11 Staff education/re-education on customer service/homelike environment; anticipating resident needs.

Webinar 12 Action Plan: Continue to build on old concepts and utilize new tools to assist in meeting the individualized needs of the residents for example changing the way we conduct

customer service rounds, morning meeting whiteboards, CNA/Nurse huddles, and trying to maintain consistent staff assignments.

Medical director involved at monthly QAPI Meeting. Competency education taught through education and monitoring. Information will be shared with the wider team at all staff meetings and ad hoc QAPI.

Success stories: 2nd qtr. - ED is hearing CNAs ask the 4 Ps and an E. Medical director asks, "Is that for you or for the resident?" Using balloons and bubbles to engage and increase movement. Working on creating an expectancy of engagement by all team members as well. 3rd qtr. – Alarm number down to 4. New activity director has many interesting things going on as well as volunteer jobs for residents interested. Team is asking what the person needs and stopping to get to know the person more than ever before and collecting ideas from all team members instead of the typical "we get rushed in our heads." 4th qtr: Now have a different way of looking at things. Take the time to talk to the person and also a focus now on anticipating needs.

| **Tallahassee** | July 20 | Aug. 20 | Sept. 20 | Oct. 20 | Nov. 20 | Dec. 20 | Jan. 21 | Feb. 21 | Mar. 21 | Apr. 21 | May 21 | June 21 | July 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alarms | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Residents with alarms | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Falls | 9 | 6 | 6 | 7 | 11 | 16 | 11 | 11 | 11 | 4 | 8 | 7 | 7 |
| Fall w/ injury | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Consulate Health Care of Tallahassee**

Contact: Robert Henige, ED

1650 Phillips Rd, Tallahassee, FL 32308 850-942-9868

Webinar 1 Action Plan: Educating staff regarding best practices.

Webinar 2 Action Plan: Educating staff regarding best practices

Webinar 3 Action Plan: Need to remind CNAs to look at the Kardex's which are very individualized already coming from the care plans. SSD is working to become a PCA and could be approached about becoming a CAN next. Maintenance person could be approached about becoming a PCA.

Webinar 4 Action Plan: Educating the staff

Webinar 5 Action Plan: Conduct trainings to introduce the "E", survey residents to find out things that motivates natural engagement. Have discovered checkers, walks outside, arts/crafts.
Webinar 6 Action Plan: Morning meeting went over some of the information, educational framework for managers. Working with team to have residents walk more, reach more, very interested in getting residents out of wheelchairs. Will share parts of webinars in 30 min. blocks for more staff and in orientation.

Webinar 7 Action Plan: Team will start to include on resident care plans more detailed info about music and going outdoors. Lavender soap in shower and drops on pillowcase for one resident as an experiment regarding sleep and falls.

Webinar 8 Action Plan: Longer wear incontinent products investigate with a vendor and think about using them with some residents, talk with team.

Webinar 9 Action Plan: Start getting highest practicable level of mental, physical and psychosocial wellbeing on care plan, ask MDS Coordinator to be responsible to get on each, new ideas from webinars to make everything more individualized.

Webinar 10 Action Plan: Will start sharing and discussing domains of wellbeing in Resident Council.

Webinar 11 Tallahassee team was asked numerous times and just couldn't pull it off with so many staffing shortages, changes and even sickness.

Webinar 12 Action Plan: The action plan for the future is to continue our daily falls review with appropriate interventions, review weekly falls trending in our SOC meeting, and monthly review of falls in our QAPI. If any trends are identified, we will implement a four point plan to address and improve outcomes.

Success Stories: 2nd qtr.: Four Ps and an E well received, many have said, did not think of it that way, to be able to be proactive and prevent falls. Focusing on being attentive to needs rather than assume needs. 3rd qtr. Got to only 4 falls in April of 2021! When asked why stated because of all the educating and focus on 4 Ps and E and more individualized everything. Education was part of each month's action plan which is noteworthy. Also used lavender in shower with a woman who was falling a lot and had no falls for the three weeks it was used prior to her moving out.

Medical director is involved in monthly QAPI meetings monthly. Competency-based education is through orientation and education by SDC and information is shared with the larger team.

**4. Webinar survey results**

Scale of (low) 1, 2, 3, 4, 5 (high) was used.

<u>Webinar 10 The Eden Alternative Domains of Wellbeing in CMS regs</u>
Was this webinar educational? Average = 4.5 (Year 1 4.6)

Was this webinar inspirational/motivational/encouraging? Average = 4.5 (Year 1 4.8)

<u>Webinar 11 Individualizing Care Plans</u>
Was this webinar educational? Average = 4.4 (Year 1 4.8)

Was this webinar inspirational/motivational/encouraging? Average = 4.5 (Year 1 4.8)

<u>Webinar 12 Lessons Learned/End Results/Send Off</u>
Was this webinar educational? Average = 4.5 (Year 1 4.7)

Was this webinar inspirational/motivational/encouraging? Average = 4.6 (Year 1 4.9)

**5. Project successes and failures**

Lessons Learned:

- Changes/turnover in staffing and management roles is unfortunately often a constant in LTC. Add to that an international pandemic. The 14 Consulate homes are to be commended for sticking with a commitment to a project and implementing person-centered proactive practices which are bound to pay off. In fact, Consulate VP of Quality of Life Bonnie Lawrence has shared, "14 of my homes participated in this project this past year. They learned so much and reduced alarms and falls significantly. I strongly recommend that you join this project if you can. It was a great opportunity. And introduced elements of culture change as well as person centered care-and that's what it is all about!" Bonnie also hared on the end results webinar that many of the practices are being introduced company wide. This is a great outcome of sustainability and replication, and we thank Bonnie and the Consulate family.
- One lesson learned is that when corporate team members can get involved, they are a huge help in collecting data, saving the team time, and with reminders for reports, etc.
- We know this and it bears out in this project that consistent staffing is key to preventing falls. With many changes toward the end of this project Aug. 2021, and a resurgence in covid and variants and people leaving the field, falls did increase in some homes.
- The homes with the most notable decrease in falls seem to keep focusing on the basics/the first practices taught in this project of being proactive, anticipating each resident's needs, particularly for the bathroom, asking the four Ps and an E proactive questions, and involving the entire team to come up with ideas that are personal to

the resident instead of old institutional, generic ideas such as alarms and waking residents during the night and in the morning.

Many thanks to the FL state survey agency and the CMS Region IV for support of this grant.

Year 2 Final Report July 2021

Submitted by Carmen Bowman, Edu-Catering, Project Coordinator

**Proactive Practices to Prevent Falls**
**Sponsored by Edu-Catering and the**
**State of Florida, Agency for Health Care Administration**

**Year 3 – Final Report August 2021 - July 2022**

This report consists of the following required updates:
1. Summary of project participation
2. Resident outcome data
3. Nursing home team action plans
4. Webinar survey results
5. Project successes and failures

## 1. Summary of project participation

15 homes joined. All remained by the end of the project however, many team members did not. Thus, some data was unattainable in several homes.

## 2. Resident outcome data AND 3. Nursing home team action plans

| **Anchor Care & Reh.** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 17 | **15** | 22 | **12** | 17 | 19 | **12** | 16 | **13** | 33 | **10** | 17 | 18 |
| Number of residents who fell | 14 | 12 | 19 | 11 | 14 | 14 | 9 | 15 | 11 | 21 | 10 | 14 | 16 |
| Number of falls w/ injury | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 2 | 0 | 0 | 0 |

### Anchor Care and Rehab

Contact: Denise Caiti, Administrator

1515 Port Malabar Blvd. NE Palm Bay, FL 32905 321-723-1235

Webinar 1 Action Plan: Rec aides to perform inquiry of resident's choice of music/mode of use target 9/17; Rec subcommittee members needed ideas and plan to spruce up courtyards target 10/1; Recreation to complete supply inventory target 9/30; Activity-create plan to have scheduled times for small groups outdoors to promote fresh air – target by 9/17.

Webinar 2 Action Plan: Team discussed B/B programs- no formal plan at center need to implement; Center QM flag above 75% for loss of B/B and ADLS, in conjunction with COVID resident not moving around as much and restorative aides being used for direct care- plan to reintegrate restorative when staffing is available; Team discussed many falls correlated to bathroom needs but no hard data known; Center has shared bathrooms in resident rooms- makes it difficult at times for care; Center wish to implement buddy system with direct care- target 10/30; Implement a program of 4 P's – target 11/30; Implement change in CNA schedules to provide overlap of workers to make room rounds- Target 11/1.

Webinar 3 Action Plan: Discussed with team proactive vs reactive definitions; Intentional with language choices; Implement the education of 4 P's- all dept- initiated 10/22 with a target of 11/30; Changed all schedules to include shift check ins with each resident for CNAs coming off and going on at shift change

Webinar 4 Action Plan: Incorporate music overhead time daily for all to gather with residents and dance/move, IDT to review walking with a purpose- walking to dining or activities, Ensure PT completes screen s/p fall, activities team to incorporate outings.

Webinar 5 Action Plan: New names from institutional A and B wing to Seabreeze and Key West with a combined resident and staff voting challenge, decorating ideas to enhance each with stimulating community feel: Seabreeze- coastal and beach themes and Key West themes both with signage and naming of all hallways i.e., streets, searching for donated items of piano/jukebox/ tiki bar.

Webinar 6 Action Plan: Dine with residents, individualized care plans reviews, utilize videos from webinar at all staff -educate on music.

Webinar 7 Action Plan: on Plan: 72-hour welcome meeting will ask set of questions for sleep patterns, list of recommended items to personalize space prior to moving in, re-initiate cove cash for 4Ps and an E.

Webinar 8 Action Plan: On boarded pain specialist, enhanced nighttime snacks.

Webinar 9 Action Plan: Started to re-design medication pass, based on resident choices and not specific times of day for all. added menu items for increased choices, residents can come to the kitchen to order, call on phone or come to the dining room and receive choices, not only the main and alternative menus offered, but Food Committee also established monthly with residents for planning menus and meals. Pending taste test meals -resident volunteers, establish a cookbook of recipes.

Webinar 10 Action Plan: During Care plans ensure resident is present and start dialogue of what goals the resident wants. I.e., personal goals individualized
Review language want to change, i.e., preferences not problems and speak to Regional Nurse consultant about changes to PCC formats.

Webinar 11 Action Plan: Created a video for both presentations required for this project but also then to use during new team member training of our reducing falls culture.

Webinar 12 Action Plan:

- 4Ps' and continue to incorporate into all educational opportunities- develop a champion with T-shirts
- Install night lights for resident with high risk of falls
- Install gait belts in each room with hooks for staff to promote restorative movement
- Lavender- utilize in common areas and rooms for residents
- Utilize video in new hire for training and awareness of falls prevention efforts
- Develop Compassionate touch and Dementia training for center
- Review restaurant style dining open dining concept
- Rehab pick a resident 1x a month to work to get out of w/c
- Continue with Welcome committee meeting within 72 hours
- Continue with room checklist, sleep questionnaire and what to bring at admission

Medical director involved during QAPI and weekly meetings. Best practices learned into competency-based education by reviewing areas of focus in manager meeting/QAPI committee and all staff meetings. Information will be shared with the larger team/used to improve resident outcomes in all staff meetings and clinical meetings monthly.

Success stories: Qtr. 1: CNAs now overlap purposefully with 30 min. so that they can transfer care. Qtr. 2: Striving for normalcy with activities such as Happy Hour. Also, for a person falling a lot out of bed in early mornings, realized and planned: check on him 4:30 am, on Kardex for CNAs and communication board for nurses and play country music and give him coffee at that early hour. Qtr. 3: Got a piano! Started themes on neighborhoods. Going to make a checklist for when a resident moves rooms and a tip to put everything as it was in former room. Qtr. 4: **Best story ever. A gentleman who was falling a lot they discovered loves to play basketball. In fact, in retrospect, they think he was probably trying to move/get exercise/play ball…got him a basketball hoop to put on the back of his door, he plays often, others can play with him from the hallway or roommate, and he has not fallen since, for 2 months. Anchor Care also made a video of their story/new way to prevent falls and now shows it during new employee orientation! Are now more creative, use themselves more as a think tank, try to breathe, step out of their roles, and think how can we improve?**

Average falls did not improve.
Falls did decrease 5 of 12 months.
Self-assessment tally of practices from 0 to 22 of 28.
QMs not submitted.

| **Balanced Healthcare** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 25 | **22** | 27 | 32 | 33 | 37 | **20** | 27 | 47 | **42** | 46 | **45** | **32** |
| Number of residents who fell | 21 | 18 | 20 | 22 | 25 | 30 | 18 | 22 | 37 | 27 | 32 | 23 | 28 |
| Number of falls w/ injury | 0 | 2 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 1 |

**Balanced Healthcare**

Contact: Tracy Johnson, Administrator

4250 66th St. No, St. Petersburg, FL 33709 727-546-2405

Webinar 1 Action Plan: Educating all staff on the 4 P's and an E.

Webinar 2 Action Plan: Utilizing all staff in the 4 P's and an E. Incorporating psychiatrist to review residents that fall for potential of medication issues.

Webinar 3 Action Plan: Utilizing phrasing of "Is there anything else I can do for you "before exiting resident area to increase engagement with residents to assist in having everything in place prior to leaving the area.

Webinar 4 Action Plan: Take one resident and assist them in attaining the goal of being out of a wheelchair.

Webinar 5 Action Plan: Resurrect music with snacks residents and staff dancing, could encourage team members to turn on radios for residents, do play radio on smoke patio and people dance. Will try to watch Web. 5 on Engagement.

Webinar 6 Action Plan: Will begin with individual lavender, lotion or drops.

Webinar 7 Action Plan: Move toward elongate breakfast times and begin asking residents about sleep preferences and care plan individual preferences and approaches.

Webinar 8 Action Plan: Begin asking and talking about highest practicable level of physical, mental, and psychosocial wellbeing in care conferences.

Webinar 9 Action Plan: Bring to MDS coordinators the idea to start incorporating in care planning as able per person/resident.

Webinar 10 Action Plan: Sharing link of webinar education with MDS coordinators. Do use residents' names could move into I care planning and adding other practices from last 2 webinars.

Webinar 11 Action Plan: Encouraging to see how others have taken the information certain aspects and make it their own.

Webinar 12 Action Plan: Continue use of lavender lotion, incorporate **challenge to therapy team monthly to get a resident moving/out of wheelchair.**

Medical director involved through weekly meetings. Best practices learned into competency--based education via small group education, individual education, return demonstration with documented competencies. Information shared with the larger team/used to improve resident outcomes via Town Hall meetings monthly, CNA meeting monthly, nurses meeting monthly.

Success stories: Qtr. 1: Better to be proactive. Saves time and frustration. Puts things into perspective. Teaching what to look for. Have a different focus. The 4 Ps and an E as opposed to whatever else it was. Individualize the person. Qtr. 2: Educate and really show excitement. 3rd qtr.: **Sharing in an orientation book for agency staff expectations including the 4 Ps and an E and had idea to bring agency staff into the cove cash reward system**. Seems to be working, use of 4 Ps and an E/being proactive as there is less hollering and less call lights. Use this: **"You spot it, you got it."** Qtr. 3: Everything we do is very individualized from day to day to care plan. April falls are down b/c very individualized, have open dining, honor sleep, and change care plans immediately. Qtr. 4: ED challenging therapy team to identify the next person who may be able to no longer use a wheelchair. Why the decrease in falls in July? A better awareness of the falls and the why's for the falls. Looking at the evenings and nighttime falls have decreased the most. I like the lavender lotion.

Self-Assessment tally of practices went from 0 to 20 (out of 28).
5 of the 12 months there was a decrease in falls.
(Average falls of pre project year was not available.)
QM improvement: Decreased incontinent episodes 52 to 47

| **OC of Dade City** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 21 | 25 | **18** | 24 | **16** | 32 | **14** | 32 | **25** | **23** | 30 | **21** | 33 |
| Number of residents who fell | 14 | 11 | 11 | 17 | 11 | 32 | 14 | 18 | 22 | 15 | 25 | 18 | 22 |

| Number of falls w/ injury | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 3 | 0 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Orchid Cove at Dade City**

Contact: Norman Harris, Administrator

37135 Coleman Ave. Dade City, FL 33525 352-567-8615

Webinar 1 Action Plan: Start getting more detailed information before a new person (instead of new admit) moves in or comes for a stay (instead of is admitted):

1. What was this person's sleeping pattern before coming here (prior location)?
2. What is this person's continence status?
3. Is this person able to express needs or do we need to anticipate?
4. Did this person experience any falls at the prior location?

Webinar 2 Action Plan: More team members involved, teach, and post the 4Ps and an E. Get more team members to watch Webinar 2 either in person in portions or watch recording link on own. Also ask for their ideas after hearing the many possible practices, weave the discussion toward more and more team members becoming PCAs, if they don't bring it up, start asking for volunteers.

Webinar 3 Action Plan: Within 48 hours meet for new residents to learn routine quicker. Cheryl to work with nurses, including agency, and therapists to remind share expectation to help residents to bathroom. Also, will teach 4Ps and an E at upcoming town hall, post in several locations and resident rooms.

Webinar 4 Action Plan: Will ask therapy team to watch webinars. Will talk with therapy about an eval by both PT and OT after each fall and to include the room and the strategy of considering more grab bars. Not offering pushes to those who can move with w/c on own. Stand with a person when they stand, do not just tell to sit down. Will consider reward system for hearing Ps and an E, for neighborhood with least falls, for getting to zero falls will have "some sort of catered event." Identified could support independence more, help to bathroom. Will research chairs in the hall and Life Safety Code 2012.

Webinar 5 Action Plan: Calendars for everyone. Start with those falling the most to identify and get on care plan.

Webinar 6 Action Plan: Will pursue lavender lotion with residents who are falling.

Webinar 7 Action Plan: Will ask MDS coordinator to start asking in care conferences what is needed for a good night's sleep.

Webinar 8 Action Plan: Will invite MDS coordinator to watch Web. 8 as she is able, and to fold into care conferences discussion with resident, family, and team of Highest Practicable Level of Physical, Mental and Psychosocial Wellbeing.

Webinar 9 Action Plan: requested several times with no response.

Webinar 10 Action Plan: Requested but not submitted.

Webinar 11 Action Plan: Requested but not submitted.

Webinar 12 Action Plan: Requested but not submitted.

Medical director involved during QAPI. Best practices learned into competency-based education via Team Talks, Town Halls. Information shared with the larger team also during Team Talks and Town Halls/all staff meetings.

Success stories: 1st qtr.: Excited for different ideas and to learn more strategies. Hold a Team Talk every day. Working toward "regular talking" instead of "institutional talking." 2nd qtr.: Drop in falls due to some of what we're doing in this project, increasing awareness by all including activities and therapies. Also having team members sign up officially from each discipline to be Fall Champions, 13 so far. Want a variety of teams represented and a lot of ideas. The director of therapy signed up herself and all her team members. Planning to do more outside, including therapy minutes raking and gardening. Did have one week in Dec. 2022 with no falls. Have asked MDS Coordinator to change language in care plans. 3rd Qtr.: Using team talks to stress the initiative to prevent falls, new team, also utilizing PCAs to sit with some residents if helpful and preventative of falls. Qtr. 4: **Consistently proactive, teach 4Ps and an E in monthly education, in the calendar, 2 inservices per month, more activities in the hallway, staffing coordinator tasked with reaching out to families to find out what were the person's activities before moved here, what brings each JOY. Noticed falls around 2 pm for a certain resident. Discovered he loved fishing, was a sports fisherman, brought him to the pond in the courtyard at that time or invited him to sit by aviary and window with the view of the pond at the same time and… his falls have decreased!** Also chair aerobics restorative and activities team working together. We champion this: **Communicate. Educate. Evaluate. Celebrate.** Have Team Talks daily.

| | | |
|---|---|---|
| Psychoactive meds | 67.6% | 5.34% |
| High risk pressure ulcer | 17.6% | 13.3% |
| Percent ability to move worsened | 41% | 29.5% |
| Self-assessment tally of 28 | 4 | 20 |

Average falls never received for year prior.
Decrease in falls 6 of the 12 months.

| **OC Daytona** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 10 | 18 | **16** | 21 | **9** | 13 | 14 | 15 | **9** | **8** | 15 | **13** | **9** |
| Number of residents who fell | 9 | 15 | 9 | 15 | 6 | 8 | 10 | 10 | 7 | 6 | 9 | 11 | 9 |
| Number of falls w/ injury | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Fall Rate | 4.66 | 7.98 | 6.75 | 8.31 | 3.74 | 5.23 | 5.68 | 6.56 | 3.63 | 3.28 | 5.76 | 5.08 | 3.51 |

**Orchid Cove at Daytona**

Contact: Angela Strauss, DON

1001 S. Beach St., Daytona Beach, FL 32114 386-258-3334

Webinar 1 Action Plan: Will post 4 Ps and an E and start teaching.

Webinar 2 Action Plan: Using 4 Ps and an E with all team members to use in resident rooms when exiting.

Webinar 3 Action Plan: Roll out the idea to residents at Resident council to check in with other residents.

Webinar 4 Action Plan: Roll out idea to residents to visit other residents at next Resident Council meeting. Reminding/educating team members to provide increased movement.

Webinar 5 Action Plan: Interest in volunteer jobs.

Webinar 6 Action Plan: Will go buy lavender lotion today and start trying it particularly with the resident who is falling the most right now. Covcash for overhearing 4Ps and an E.

Webinar 7 Action Plan: Talk with residents at RC about snacks at night with protein and maybe dessert then instead of a meal, find out desires, preferences with goal of sleeping better.

Webinar 8 Action Plan: Idea to work with activities, maybe social services, to ask people "How do you want to live?" and "not just all that medical stuff." Also, MDS coordinator to begin talking with resident, family, team how each resident defines highest practicable level of mental, physical, and psychosocial wellbeing separately.

Webinar 9 Action Plan: MDS coordinator to begin to talk about the domains of wellbeing in care conferences one at a time, going the full quarter to catch everyone and then move on to another domain.

Webinar 10 Action Plan: Changed from interventions to approaches.

Webinar 11 Action Plan: Liked how OC Venice involved all and move in that direction.

Webinar 12 Action Plan: We are attempting to incorporate the 4 Ps for all disciplines and post them where we can for all out staff, family, and residents to become familiar with.

Medical director involved during QAPI. Best practices learned turned into competency-based education via signage around building and at all team meetings. Information shared with the larger team via monthly meetings.

Success stories: Qtr. 1: **"Falls, who likes them?"** Qtr. 2: Administrator makes a point to wave to residents for movement. Administrator to offer reward to whole community if falls reduce in the month and will ask what they want to do. Qtr. 3: Why are falls down in March? "New team and teamwork." Qtr. 4: Individualizing care plans, more personalized preferences, nursing team is using 4Ps and an E.

Average falls for year prior was unavailable.
QMs? Requested but not submitted.
Self-Assessment tally. Requested but not submitted.
In 6 of 12 months, falls reduced.
First month number of falls 18 reduced to half in last month 9; as did fall rate 7. 98 to 3.51.
Only 2 months with a major injury from a fall.

| **OC of Kissimmee** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 12 | **2** | 7 | 9 | 14 | **3** | 4 | 11 | **9** | **8** | 8 | 9 | **8** |
| Number of residents who fell | 12 | 2 | 7 | 9 | 14 | 3 | 4 | 6 | 5 | 6 | 7 | 6 | 5 |
| Number of falls w/ injury | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Orchid Cove at Kissimmee**

Contact: Jose Alicea, Administrator

320 Mitchell St. Kissimmee, FL 34741 407-847-7200

Webinar 1 Action Plan: 1) Monitor times of day falls occur to see trending patterns; increase bowel and bladder checks on each patient; teach on timely answering of call lights. Making sure call lights are within reach upon leaving resident rooms; 30 day falls free. Educations with posttest.

Webinar 2 Action Plan: Walking checks between on coming and off going CNA staff each shift change; Creating culture by use of language in-service; in-service staff and include posttest on being proactive about resident's bathroom needs.

Webinar 3 Action Plan: 4 Ps and E laminated and added to the badge. One training so far. OT and PT eval of resident room for prevention of falls ideas.

Webinar 4 Action Plan: Educate on being proactive instead of reactive; Helping residents to do things no one would expect them to be able to do; Inservice on top reasons for fall, incorporate music and dancing in activities.

Webinar 5 Action Plan: Incorporate frame pictures of scenery into décor. Activity Department to be more involved with fall prevention project.

Webinar 6 Action Plan: More use of consistent staffing, help with improving residents' strength by use of grab bars, nurses sitting in hall to chart to see residents better.

Webinar 7 Action Plan: 1) Personalizing resident's choice of when to sleep and when to be woken up. 2)Scheduling Activities to promote more sleeping. 3)Offer foods to support sleep.

Webinar 8 Action Plan: Educate staff on what it means to explore the residents' highest practical level of physical, mental, and psychosocial well-being.

Webinar 9 Action Plan: Get CNAs acclimated to thinking that way. We see as patients. Pick one domain of wellbeing at a time per quarter, roll into care conference.

Webinar 10 Action Plan: Always reminding team for individualized, not cookie cutter care planning. And will ask MDS coordinator to watch webinar since regarding care planning.

Webinar 11 Action Plan: Incorporating best practices learned from other teams: Language change with emphasis on culture. Assigning Guardian Angels to neighborhoods

Webinar 12 Action Plan: Incorporating best practices learned form second half of the team. T- shirts that say Reduce falls on the front 4Ps AND E on the back.

Bimonthly fall project updates with medical director. Best practices learned into competency—based education via call light competency. Information shared with the larger team/used to improve resident outcomes via monthly and PRN educational in-services and competencies.

Success stories: Qtr. 1: **DON uses True/False tests, however, never uses a False so that people remember the truth, i.e., what causes falls… excellent practice!** Decrease in falls basically because all are paying more attention to residents. You check in at a hotel. Qtr. 2: Falls down from 14 to 3 in the month! Why? "We are getting better at being proactive to prevent falls." Pursuing "homey and human" instead of homelike. "Residents can to more than we think they can." When DON met and evaluated a new resident, she thought he couldn't talk had a stroke made grunting sounds could hear down hallway looks in coherent, but he is trying to communicate with us. Asked therapy for a communication board which he now uses and is walking he has come so far because we addressed his communication. Grab bars mean a lot to DON as own mother was helped with a grab bar, stood for the first time at home. Rehab screen when there is a room change and making it a point to ensure that the individual's things are placed in the very same place as prior room. We don't like all these people congregating at the nurses' station because they need to be active, doing something. boring. Challenge yourselves to create places where people would want to come coffee bar, Teatime, music – have DJs every day. Qtr. 3: Plans to make badge buddies of the 4Ps and an E. DON: "I'm so schooled, I need to grow and unlearn the institutional ways and see people as people not as only patients." Qtr. 4: Learned to look at the nursing home as HOME. Months that falls were low were months we had more concentration on the 4Ps and an E, proactive rather than reactive. Go back one a month to one of the subjects and address in inservice and use questions all true, never false as we do not want to muddy up our brains. **Let them remember what we want them to remember. And not muddle their minds**. Residents also looking out for each other. "Don't get up" and alerts staff of other residents' needs. More activities and with music and dancing. One person we thought could not come back from a stroke. Could not move or speak but moved out in May. He could express his needs instead of yelling. Daughter was amazed. Using a walker, came this far, why? This project has taught us a lot. So much more Enjoyed it. Very informative. Opened up options and different ideas to make better.

Self-Assessment from 8 to 26 of 28 practices.
Average falls increased.
Falls decreased in 5 of 12 months.
QMs not submitted.

| **OC of LaBelle** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 24 | **14** | 37 | **21** | 23 | **18** | 31 | **20** | 46 | **33** | 35 | **23** | **17** |
| Number of residents who fell | 20 | 9 | 17 | 13 | 11 | 12 | 18 | 14 | 26 | 18 | 24 | 15 | 13 |
| Number of falls | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 |

| w/ injury | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Orchid Cove at LaBelle**

Contact: Kari Whidden, DON

250 Broward Ave. LaBelle, FL 33935 321-723-1235

Webinar 1 Action Plan: Inquiring of resident sleep patterns and needs such as a bedtime snack and why restless, etc.

Webinar 2 Action Plan: Have developed a PIP which includes to in-service staff on identifying and anticipating resident needs and address root cause through individualized care planning that includes identification of bathroom needs and establishing a schedule.

Webinar 3 Action Plan: Added to PIP to educate all team members on 4 P's and an E: Pain, Personal needs, Positioning, Personal Items and Engagement. Encourage staff to utilize 4 P's and an E to be proactive in meeting needs. Laminated posters in staff areas.

Webinar 4 Action Plan: Added to PIP to initiate Walk to dine… residents who are able to walk will be assisted/encouraged to walk to the dining room for meals.; Moovin' and Groovin' exercise to be led by restorative and activities.

Webinar 5 Action Plan: Encourage families to bring in picture books/ memory books for residents. Picture wall of residents in the community (hall).

Webinar 6 Action Plan: Chamomile teatime at 130pm, more outdoor activities such as bowling and kickball.

Webinar 7 Action Plan: "Plan" is to initiate open dining as of 3/15 Mon-Fri for Breakfast and Lunch. We will then re-evaluate after 30 days for the dinner meal. We are also educating our staff on asking what time they want to go to bed/get up. All to be introduced during our Resident Council meeting.

Webinar 8 Action Plan: Begin to ask in care conference about and together define Highest Practicable Level of Physical, Mental and Psychosocial Wellbeing.

Webinar 9 Action Plan: 4P's & E Shirts for residents and staff.

Webinar 10 Action Plan: MDS to update care plans and individualize them using name/ make care plans more personal.

Webinar 11 Action Plan: Development of competencies for staff, Cove Cash to those who practice 4P's/E.

Webinar 12 Action Plan: Continue to inservice and educate staff. Continue with the interventions that are effective. Develop competencies for staff ensuring this knowledge is retained.

Medical Director is involved during monthly QAPI meetings. Best practices learned turned into competency- based education via in-services and PDSA cycle for implementation of PIPS and quality monitoring. Information shared with the larger team via shared with the management team during stand-up meeting and all staff through education. Staff are encouraged to share their ideas.

Success stories: Qtr. 1: Reduced Falls. Although some residents who were falling a lot moved out, the other reason team identifies for fewer falls is that residents are out and about again, more movement which is the focus of Webinar 4. "We've learned when residents are antsy and fidgety, take them to the bathroom and they're no longer antsy or fidgety." Qtr. 2: Team working to increase movement for residents personally; DON does handwashing, therapy director loves puzzles so has one out and invites residents to work on with her; also, a large coloring page in the hall for anyone interested. Doing Glamour Shots for Valentines. Qtr. 3: **During March call, team decided to make t-shirts and did! Started wearing them April 12th both team members and residents and ... falls decreased April (33) compared to March (46)!** They have brought awareness and we are paying attention more to needs of residents. Qtr. 4: Started lavender lotion with one resident before bed, a month later, no falls!

Self-Assessment Practices increased 10 24
Psychoactive medication use (long stay) 2.58% 0
Average falls increased.
Falls decreased in 7 of 12 months.

| **OC of Longwood** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 11 | 18 | 21 | **20** | **13** | 20 | 23 | 28 | **13** | **9** | 23 | **20** | 26 |
| Number of residents who fell | 5 | 8 | 18 | 13 | 10 | 7 | 9 | 22 | 10 | 9 | 23 | 20 | 26 |
| Number of falls w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |

**Orchid Cove at Longwood**

Contact: Eric Johnson, Administrator

1520 S. Grant St., Longwood, FL 32750 407-339-9200

Webinar 1 Action Plan: Look into cross training.

Webinar 2 Action Plan: Start to talk to team members about project, being proactive, anticipatory, etc.

Webinar 3 Action Plan: 4Ps and an E to be passed out and posted and taught. All team members informed of increase in falls and asked for ideas how each can prevent.

Webinar 4 Action Plan: Will ask AD to watch webinar and come with ideas and then decide.

Webinar 5 Action Plan: Invite AD to watch webinar and discuss ideas including a book club and opening up for volunteers to lead it.

Webinar 6 Action Plan: Lavender lotion before bed with the nine residents falling the most in their rooms add to treatment sheet.

Webinar 7 Action Plan: Open dining instead of a specific time such as 8 to 10 am. Start talking about how this could work.

Webinar 8 Action Plan: Roll highest practicable into care conference.

Webinar 9 Action Plan: Roll domains of wellbeing into care planning, involve and encourage MDS coordinator to be gate keeper of great care plans including starting to ask about seven domains of wellbeing, maybe starting with only 1 such as Identity. Focus on it for a quarter and then move on to a different domain.

Webinar 10 Action Plan: From care plan conference, if an idea comes up i.e., doing a bathroom schedule it is put into place and shared with team members.

Webinar 11 Action Plan: We learned from Webinar 11 that each facility has very different practices for tackling falls. The interventions put in place have to be resident centered and tailored to the residents likes and dislikes and took the idea from Kissimmee to revamp activities to include local history.

Webinar 12 Action Plan: We learned from Webinar 12 that the practices and procedures put in place must be reinforced and reevaluated regularly to remain effective. We also learned more innovative fall approaches that other buildings have devised.

Medical director involved during QAPI, new MD and will be in building a couple times a week. Best practices learned into competency-based education, at the least, at annual training. Information will be shared with the larger team and used to improve resident outcomes in morning meetings.

Success stories: Qtr. 1: Passing on the recording links to entire team. Very interested in giving individual care instead of generic. Qtr. 2: Using lavender with warm washcloths after meals. Qtr. 3: Why are falls down for Mar? Open dining is the standard, we do not wake people up, creating life, Happy Hour, Book Club, sit, and talk be together, very engaging. DON: “Can we keep going (in the grant project)?” Qtr. 3: Have taken to heart that there is an institutional feel in the building and doing something about it. Everything is grey for instance. Qtr. 4: Administrator: We have had a lot of success. Using the 4Ps and an E. really pushed to all our teams. Now sharing statistics for falls with everyone. Historically a lot of falls. Overall, have decreased by 40%! **Including therapy team, brought into and more of a process of talking about falls even if the person has not had a fall. Increased communication with residents and families more than medical management. Looking at environment in room, being proactive, what to see.**

In 5 of 12 months, falls did decrease.
Average of falls increased.
Only 1 fall with major injury in 12 months.
Self-Assessment practices 9 to 23 of 28.
QMs requested but not submitted.

| **OC of Naples** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021* | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 8 | **6** | 7 | 11 | **6** | 8 | 10 | 11 | **5** | 15 | **12** | **10** | **5** |
| Number of residents who fell | 7 | 5 | 6 | 9 | 6 | 7 | 9 | 8 | 4 | 12 | 9 | 8 | 5 |
| Number of falls w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Orchid Cove at Naples**

Contact: Hershel Caywood, ED

2900 12th St. N, Naples, FL 34103 239-261-2554

Webinar 1 Action Plan: Start getting more detailed information before a new person (instead of new admit) moves in or comes for a stay (instead of is admitted):

- What was this person’s sleeping pattern before coming here (prior location)?
- What is this person’s continence status?
- Is this person able to express needs or do we need to anticipate?
- Did this person experience any falls at the prior location?

Webinar 2 Action Plan: More team members involved, teach, and post the 4Ps and an E. Get more team members to watch Webinar 2 either in person in portions or watch recording link on own. Also ask for their ideas after hearing the many possible practices, weave the discussion toward more and more team members becoming PCAs, if they don't bring it up, start asking for volunteers.

Webinar 3 Action Plan: Printed out the 5 Ps laminated; Education on the 5 Ps at the next town Hall meeting; Place each laminated sheet on the back of the resident's room door; Monthly education at Town Hall regarding culture changes to include new language; Each month at town hall we will educate on the "new language" of the month. For example: instead of using toileting, encourage staff to use bathroom and each time it's heard being used $1 Cove Cash is given.; Managers to adopt "proactive checking in" more frequently with their rooms assigned for Angel Rounds; New list of Angel Rounds sent to Department Heads; Before leaving resident's room ask if that resident has their important items in reach, aside from making sure call light is in reach, bed locked and at proper height

Webinar 4 Action Plan: Will increase movement by helping residents get to bathroom more often in order to move more and help prevent falls as root cause analysis of last 6 falls in Nov. were all bathroom related. Reteach 4Ps and an E with capes, superpower theme, etc. Reward all team members if get to zero falls, and if overhear asking residents the 4 Ps and an E.

Webinar 5 Action Plan: approached many times, did not receive with numerous changes

Webinar 6 Action Plan: approached many times, did not receive with numerous changes.

Webinar 7 Action Plan: Next All Staff Town Hall and Ad Hoc Committee Meeting review the following topics and encourage feedback for selection of approaches the Community will use re: Honoring Sleep. Ad hoc committee with SMART goals addressing.

Webinar 8 Action Plan: Next All Staff Town Hall and Ad Hoc Committee Meeting review the following topics and encourage feedback for selection of approaches the Community will use re: highest practicable. Ad hoc committee with SMART goals addressing.

Webinar 9 Action Plan: Next All Staff Town Hall and Ad Hoc Committee Meeting review the following topics and encourage feedback for selection of approaches the Community will use re: Eden Alt domains of wellbeing. Ad hoc committee with SMART goals addressing.

Webinar 10 Action Plan: The IDT decided to focus on establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care, through active communication with the resident and/or representative.

Webinar11 Action Plan: Intend to incorporate Fall Champions as other teams did.

Webinar 12 Action Plan: Administrator no longer at building and no other team members were brought into project.

Medical director involved during QAPI. Best practices learned into competency-based education via Team Talks, Town Halls. Information will be shared with the larger team and used to improve resident outcomes via Team Talks and Town Halls/all staff.

Success stories: Qtr. 1: **This team likes the idea of being proactive, explaining it in a very interesting way: "Solve the issue even before it happens." What could we do different to meet their needs?** 4Ps and an E on the back of resident room doors. Looking at life a little different with new activity director. Qtr. 3: Education is ongoing regarding proactive checking in… giving cove cash to staff members when new language is heard. A resident asked for a volunteer administrative job, administrator gave, and he comes every day, sometimes early, but never late. Qtr. 4: Really resonated from the webinar that residents should decide their goals for their life, on their care plan. Felt project gave real practical practices like open dining and sleep preferences and volunteerism and pointing out resident's goals from the CMS regulations. Now sharing fall rate with all team members, one nurse really got into not wanting a fall during her shift, increased observation, checking in with residents using the 4Ps and an E.

**ZERO major injuries from falls!**
Decreased average falls per month from 11.25 to 8.83!
Falls decreased in 6 of 12 months.
QM data and Self-Assessment tally unavailable as administrator no longer at the building at the end of project and never brought any other team member into the project.

| **OC of New Port Richey** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 24 | 32 | **28** | 35 | **29** | **22** | 45 | **35** | **28** | **27** | 43 | **38** | **26** |
| Number of residents who fell | 21 | 22 | 19 | 35 | 18 | 17 | 29 | 26 | 18 | 21 | 28 | 24 | 21 |
| Number of falls w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 |

**Orchid Cove at New Port Richey**

Contact: Nicole Francis, Administrator

4927 Vorhees Rd. New Port Richey. FL 34653 727-848-3578

Webinar 1 Action Plan: Begin to look at trends in falls and residents who have had frequent falls and begin to target those residents for new approaches to prevent falls.

Webinar 2 Action Plan: Meet with CNAs to determine the best practices that we can begin to implement most effectively. We will meet in small groups and 1:1 with staff to begin those conversations to implement proactive strategies to prevent falls.

Webinar 3 Action Plan: We will continue to expand upon the residents we've already discussed and begin to discuss more, and we will begin to include family members and other departments aside from nursing.

Webinar 4 Action Plan: We have focused on ensuring that the Kardex is up to date with fall interventions and strategies that have been implemented to ensure they are communicated to agency staff that are not here consistently and are not familiar with our residents. We have also engaged activities to assist with increasing movement as we have a new activity director.

Webinar 5 Action Plan: We met this week and discussed starting a new project on the North wing (long term side) to make it more home like. We are going to paint the common area, hang pictures in frames and get mailboxes for outside the rooms. We are going to work with the recreation department to implement additional meaningful engagement strategies such as those discussed on the call, which also lends itself to our recent attempts to increase movement.

Webinar 6 Action Plan: The Activity Director will incorporate more outdoor time into the calendar, will also start scheduling outings again. Work on consistency with agency staffing by contracting with full time agency staff and/or trying to assign the agency staff that come to the facility frequency to consistent assignments when possible. We will meet and review fall trends to determine if there are any high fall times that we need to focus on.

Webinar 7 Action Plan: We are going to try to find out what the resident's preferences are related to their sleep patterns and waking times. We often wake residents up in the morning to get ready for the day or to have breakfast, and we have an area of opportunity to improve upon honoring their preferences. We also have some areas of opportunity to identify why some residents are having trouble sleeping and try approaches to assist.

Webinar 8 Action Plan: The facility is fast paced with a great deal of turnover for admissions and discharges, and we end up doing a lot of room changes, and we could improve upon orienting a resident to a new room having team members do it each time they go in for the first few days. We also can improve upon finding meaning and purpose for each resident, and that is something we can incorporate into their care plan meetings and initial assessments with the various departments.

Webinar 9 Action Plan: We tend to focus on the goals of short-term residents, but there is an opportunity for us to work with the long-term residents on what their goals are and how we can work with them to achieve them. This is something that both nursing and activities can assist with. We are also continuing to work on changing language and will use town hall and small group meetings to communicate these changes with the staff.

Webinar 10 Action Plan: We are going to include more conversations about the resident's goals and preferences in our care plan meetings and interactions with residents. More family members are starting to attend care plan meetings, which gives us an opportunity to solicit information and feedback from them for the residents are not able to provide it to us. We would like to start implementing "I" care plans starting next quarter and slowly start to phase out the traditional care plan model. Our care plans follow what we know to be the traditional model for care plans and always have room for improvement.

Webinar 11 Action Plan: We are going to utilize some of the best practices learned from other teams during this call to implement additional strategies. We loved some of the out of the box ideas that other facilities came up with and implemented.

Webinar 12 Action Plan: We are going to implement some additional strategies to engage the staff such as making t-shirts and incentive programs to engage the staff in these best practices.

Medical director visits three times per week and is actively engaged with members of the IDT upon each visit. He will be notified and involved during his visits. Best practices learned into competency--based education will be used during new hire orientation and during annual competency completion. Information will be shared with the larger team/used to improve resident outcomes during interdisciplinary team meetings and in group huddles or 1:1 interaction with direct care staff.

Success stories: Qtr. 1: Wanting to get away from incontinent briefs to same money make more dignified for resident and less work for staff, takes less time to take to bathroom than change person and bed, get urine off skin, etc. Going to put the responsibility on team members to watch webinars. Mindful. Make an effort to ask resident instead of plan to check and change every 2 hours. Skin treatments are also reactive as opposed to proactive. Qtr. 2: Working toward not having any get up list and instead working toward learning resident preferences/routines/natural awakening. Qtr. 3: **"Everyone who comes into this building is at risk for falls. Diagnoses, meds, history of falls. Even if not clear cut, at risk for one reason or another. People are at risk. Honestly everybody is at risk. New - will fall. Moving rooms - will fall." Working to get rid of "toileting" say it all day: When last toileted? Needs toileted. Toilet before bed, etc. We ask rehab guests their goals but not those who live here, will begin. We tend to be generic. Not person centered, don't know what resident thinks, set goals according to what we think, not the person. Same goals over and over."** Qtr. 4: **This project helped us to think outside the box of the norm of the institution. Challenged what we know to be the norm. We include our new hires into our new strategies, and they are excited, they want to help prevent falls.**

Quality Measure improvements
Psychoactive med use 10 to 7 %
High risk pressure ulcers 22.92% to 15.20%
Improvements in function short stay 77.38 to 85.1%

Ability to move worsened long stay 27.89 to 16.8%
Self-assessment Tally of project practices 4 to 19 practices (of 28).
In 8 of 12 months falls decreased.
Average falls increased.

| **OC at Oldsmar** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 9 | **8** | **5** | 5 | 7 | 10 | **7** | 14 | 16 | **11** | **9** | 11 | **7** |
| Number of residents who fell | 6 | 6 | 5 | 4 | 7 | 6 | 6 | 8 | 12 | 7 | 8 | 7 | 5 |
| Number of falls w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |

**Orchid Cove at Oldsmar**

Contact: Artisha Alston DON

3865 Tampa Rd, Oldsmar, FL 34677813-855-4661

Webinar 1 Action Plan: Introduce 4P's and E.

Webinar 2 Action Plan: Being proactive with bathroom needs and all resident needs. Knowing the schedule of your resident (using bathroom upon awaken/sleep, before and after meals).

Webinar 3 Action Plan: Four P's and E', becoming proactive.

Webinar 4 Action Plan: Increasing movement for all residents. Chairs placed throughout hallways according to LSC 2012.

Webinar 5 Action Plan: Bio books on residents to help with engagement, having families bring in birdhouses or bird baths. Getting aroma therapy started (holiday scents). More cooking classes, getting an aviary, planting a butterfly garden, paint birdhouses and hang out resident room windows, resident library on a cart.

Webinar 6 Action Plan: Adding more grab bars in rooms/bathrooms. Consistent staff (reducing agency use) and getting outside more for activities (music on patio).

Webinar 7 Action Plan: Getting resident on their normal sleep routine (maybe they worked night shift or have always been night owls).

Webinar 8 Action Plan: Being practical with resident needs (if you don't use it, you lose it) encouraging resident to do what they can. Changing the lingo.

Webinar 9 Action Plan: Proactive idea to orient new people to their new room knowing they will fall in a new setting. Also, will use special instructions from PointClickCare to prompt team members to remind/orient new person during first week, beyond just the first day. Also, OT/PT to orient to new room, also grab bars considered.

Webinar 10 Action Plan: Getting with MDS to individualize residents' care plans.

Webinar 11 Action Plan: Considering essential oils, namely lavender, to offer residents to reduce falls.

Webinar 12 Action Plan: Getting residents outside more with activities and therapies.

Medical director involved bi-weekly during his visits, phone calls, QA meetings, Psych meetings, and PRN. Best practices learned into competency-based education through Townhall meetings, Morning meetings, Clinical meetings, QA meetings, Psych meetings CNA meetings, nursing meetings, and direct education. Information shared with the larger team and used to improve resident outcomes through Townhall meetings, Morning meetings, Clinical meetings, QA meetings, Psych meetings.

Success stories: **Falls reduced. Only 3 falls in two weeks. New DON has used 4 Ps in another setting. Using 4Ps and an E now and really working. To anticipate needs and be proactive reduces falls and it is working. "Using the bathroom is the first thing we learn and the last thing we hold on to. Urge hits. We don't plan ahead. I got to go now. If you anticipate needs, can help encourage and support that need will be taken to bathroom which decreases use of call lights, takes less time and we don't want falls."** Qtr. 2: Approaching resident council president about checking in with other residents. MDS coordinator to include more detailed information re: bathroom use and engagement into care plans. New act director has more real-life happening bake sale, and ways to be up and moving more, "she's all about it." Qtr. 3: Going to use PCC's Special Instructions to remind team to orient new people more than once. Qtr. 4: Doing much more thorough medication reviews, that is helping with falls. Looking into neighborhood names. Plan to roll it out to have all check in more often once we have the last manager position filled.

Average falls was unavailable, never submitted for partial year prior.
Falls did decrease in 6 of 12 months of the project.
QMs not submitted.
Self-assessment not submitted.

| **OC at Palm Harbor** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 16 | 21 | **12** | **10** | 17 | **11** | 22 | **17** | 18 | 18 | Not sub. | Not sub. | Not sub. |
| Number of residents who fell | 7 | 9 | 4 | 8 | 12 | 9 | 12 | 11 | 11 | 11 | Not sub. | Not sub. | Not sub. |
| Number of falls w/ injury | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | Not sub. | Not sub. | Not sub. |

**Orchid Cove at Palm Harbor**

Contact: Stacy Caccamise, DON

2600 Highlands Blvd N. Palm Harbor, FL 34684 727-785-5671

Webinar 1 Action Plan: Education to team members used proactive thinking with staff regarding each residents' fall.

Webinar 2 Action Plan: Being proactive! Anticipating potential needs.

Webinar 3 Action Plan: No pass zones like in hospitals whereby no team member can pass a call light.

Webinar 4 Action Plan: Walk to dining room and around building.

Webinar 5 Action Plan: unable due to leadership changes

Webinar 6 Action Plan: unable due to leadership changes

Webinar 7 Action Plan: unable due to leadership changes

Webinar 8 Action Plan: unable due to leadership changes

Webinar 9 Action Plan: Lavender lotion application to two residents falling lately. Will print 4Ps and an E handout and pass out to all staff, raise awareness in daily meetings and hold a contest between shifts (most falls during evening shift right now) and possibly use cove cash to reward team members if overheard asking the 4Ps and an E proactive questions to reward proactive practices to prevent falls.

Webinar 10 Action Plan: Although requested, not submitted.

Webinar 11 Action Plan: Although requested, not submitted.

Webinar 12 Action Plan: Although requested, not submitted.

Medical director involved in QAPI monthly. Best practices learned into competency-based education via weekly bi-weekly education with regional nurse discuss go to clinical SDC and put into competencies. Information shared with the larger team and used to improve resident outcomes via daily meetings, weekly risk meetings, monthly QAPI, DON meeting weekly, monthly Town Meetings.

Success stories: Qtr. 1: MDS coordinator very interested in many ideas to prevent falls namely essential oils. Using diffusers and taking a class to learn how to mix own oil blends. Lavender especially is linked to fewer falls Qtr. 2: team unavailable. Qtr. 3: Nurses decided to implement "therapeutic lotion application" ("old school" they called it) for several residents who are falling right away. Qtr. 4: Team is checking in with residents more. Have discovered that Prevail is the better product for the money re: incontinence.

Self-Assessment: Although requested, not submitted.
QMs: Although requested, not submitted.
Average falls actually increased from 10 to16.
Months falls decreased 3 of 9 months in which falls were reported.

| **OC at Rockledge** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 12 | 14 | **9** | 14 | **11** | 15 | 15 | 15 | 17 | **13** | **12** | Not sub. | Not sub. |
| Number of residents who fell | 11 | 10 | 7 | 12 | 10 | 11 | 11 | 11 | 15 | 11 | 10 | Not sub. | Not sub. |
| Number of falls w/ injury | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | Not sub. | Not sub. |

**Orchid Cove of Rockledge**

Contact: Danielle Rappleyea, DON

1775 Huntington Lane, Rockledge, FL 32955 321-632-7341

Webinar 1 Action Plan: Activities team do activity with residents to plant lavender and then keep in their room.

Webinar 2 Action Plan: Sharing 4 Ps and E.

Webinar 3 Action Plan: Consider moving into more and more team members checking in, being more proactive than reactive.

Webinar 4 Action Plan: Idea to create more physical activity offerings.

Webinar 5 Action Plan: Catering to resident interests. Idea to create a questionnaire. Idea to have a contest between the two neighborhoods for fewest falls. Idea to use COVcash to reward words wanted.

Webinar 6 Action Plan: Starting competition between units to try reducing number of falls. The unit with the least falls will have food ordered for them!

Webinar 7 Action Plan: Encourage employees to respect resident's sleeping habits and mealtimes. Offer always available menu when resident wakes up. Start talking about sleep, in care conference.

Webinar 8 Action Plan: Have residents be more involved in assisting with activities/events as well as asking residents what they would like to be involved in to help them achieve the highest level of well-being.

Webinar 9 Action Plan: Garden club, residents helping with acts. Copies to all. Involve MDS coordinator more.

Webinar 10 Action Plan: Although requested, not submitted.

Webinar 11 Action Plan: Although requested, not submitted.

Webinar 12 Action Plan: Although requested, not submitted.

Medical director is invited to be on calls. Best practices learned into competency--based education to enhance sustainability and regulatory compliance via conduct trainings with staff. Information will be shared with the larger team/used to improve resident outcomes through huddles.

Success stories: Qtr. 1: Management team will be approached to become cross trained as PCAs. Qtr. 2: **Noticed falls taking place when a resident moves to a new room and our fault. Not used to the room. Looking into more grab bars including vertical to be available. Take more time to familiarize person with new room. Will add to PCC Care Profile Special Instructions and Kardex to keep familiarizing person with new room for a certain period such as a week. Also need to remind all to put the person's things in the very same spot. "We mess up the system" for the person causing a fall.** Using covcash to reward hearing the 4 Ps and an E and can save it up for a 42-inch TV all want! Thought of a few residents to approach and 2 family members who come and stay a while to become volunteer visitors and learn the 4 Ps and an E and are intentionally requited to help reduce falls, let along boredom and loneliness! Qtr. 3: Working on meaningful engagement

in rooms to go with the more meaningful engagement outside of rooms such as the garden club and residents helping with activities. Qtr. 4t: Tried lavender plants for residents to have in their rooms but were hard to keep up with and did not give off a lot of the desired scent, now using lavender lotion and body wash. Many falls while residents are in their rooms. "We now attempt to have residents attend activities. Even when residents choose to not go to all activities offered, we have placed activity boxes at the nurse's stations with different items to occupy their time." A contest between our two neighborhoods revealed the LTC had a major advantage over rehab with people there for therapy services who would walk and transfer on their own to work towards their goal of going home. **Offer our residents who stay up later the option of herbal teas to assist them in relaxing before bed. Some love it.**

Self-Assessment: Although requested, not submitted.
QMs: Although requested, not submitted
Average falls unable to be determined.
Months falls decreased in 4 of the 9 months reported.

| **OC at Stuart** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 9 | 23 | **14** | 20 | 14 | 25 | **24** | **9** | 10 | 21 | **12** | 12 | 15 |
| Number of residents who fell | 17 | 18 | 8 | 18 | 8 | 16 | 13 | 9 | 10 | 11 | 12 | 10 | 11 |
| Number of falls w/ injury | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |

**Orchid Cove at Stuart**

Contact: Rose Sincere, Administrator

4801 SE Cove Rd., Stuart, FL 34997

Webinar 1 Action Plan: Identifying residents affected and at risk to prevent falls and educate staff on fall prevention. Ongoing.

Webinar 2 Action Plan: Updating care plans to individualized, each persons' specifics.

Webinar 3 Action Plan: Implementing best practices/frequent checks from all staff. Guardian Angels starting.

Webinar 4 Action Plan: Getting residents more engaged, involved, and moving more by adding more lively activities of preference.

Webinar 5 Action Plan: Creating thinking – will implement routine, weekly outing and different music offering with the use of instruments to engage residents. Will use a team approach to implement/promote meaningful engagement.

Webinar 6 Action Plan: Maintaining consistent staffing in effort for residents to build good relationships with direct care staff.

Webinar 7 Action Plan: Facility will honor, support, and promote sleep according to residents' preferences to prevent/reduce falls.

Webinar 8 Action Plan: Facility will reevaluate residents through rehabilitation, nursing assessment and residents' input in order to help them reach their highest potential and wellbeing.

Webinar 9 Action Plan: Implementing the Eden Alternative to promote quality residents' well-being and the concept of care partnership.

Webinar 10 Action Plan: Write/customize care plans to residents' specifications/ individuality (preferences, habits, etc..).

Webinar 11 Action Plan: Continue to educate staff, utilize partners like hospice to provide education and demonstrations to staff.

Webinar 12 Action Plan: Utilize PCC drop down Special Instructions menu but then for others dietary and housekeeping. Use email to directors.

Medical director involved in QA meeting, weekly visits and as needed. Best practices learned into competency-based education via staff training/education/participation with feedback, audit/monitoring tool. Information will be shared with the larger team and used to improve resident outcomes through Team Talk, facility daily communication tool.

Success stories: Qtr. 1: We don't anticipate. We're not proactive. When I'm bedside as a nurse, I know my residents' location. I don't like all that paperwork. I don't want my residents to get hurt, that's even more paperwork. Going to the bathroom is better. They can't wait. Call light on or think they can go alone. They're not used to asking someone to help them go to the bathroom., therefore they're just going to get up and go. One resident it was realized that when he points it means he needs the bathroom. Qtr. 2**: Administrator giving the okay for more outings. Once a week is the goal. "CNAs know the 4 Ps and an E by heart." DON leads karaoke monthly and all love it.** Qtr. 3: SDC orienting agency staff to 4Ps and an E. "They like it here." Including individualized movement on care plans. Administrator is energized by trying to get to ZERO! Qtr. 4: **DON: We jazz it up, make it bounce, residents really like that, moving more, 7 days a week, twice a day somedays, DON passing through will do fist bump, will sing a song on karaoke, life can be monotonous, have to**

**make it interesting.** Helped one person get out of a wheelchair moved to New York without the wheelchair, walking.

Average monthly falls decreased from 20 to 18.
Self-Assessment pre project 15 to post project 19.
Falls decreased 4 of 12 months.
QM Improvements:
Decreased use of anti-psychotic meds 62% to 31.6%
Psychoactive meds use long stay 15.9% to 5.1%
Experiencing one or more falls with major injury 3 to 2.49
Decreased number of pressure ulcers 10% to .82%
Decreased incontinent episodes 88% to 71.11%
Frequently or always incontinent 72.2% to 45%
Improved performance transfer/locomotion and walking 22% to 73.84%
Percent of residents whose ability to move independently worsened long stay 24% to 11.5%

| **OC at Venice** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 12 | 12 | 15 | 16 | **11** | 12 | **9** | **5** | 8 | 9 | 12 | **11** | 12 |
| Number of residents who fell | 12 | 12 | 8 | 15 | 11 | 8 | 5 | 5 | 5 | 4 | 7 | 8 | 8 |
| Number of falls w/ injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |

**Orchid Cove at Venice**

Contact: Dana Bedford, Administrator

1240 Pinebrook Rd., Venice, FL 34285 941-488-6733

Webinar 1 Action Plan: Interview residents for more details about themselves and engagement.

Webinar 2 Action Plan: Working on bathroom schedules, learning more about the person and “a schedule that fits them not us.”

Webinar 3 Action Plan: Teach 4Ps and an E and dig deeper into engagement for each person.
Webinar 4 Action Plan: Using the bathroom more often = more movement. Working with nurses, myself and CNAs say Jimmy always standing, we walk with him. Could still promote 4Ps and an E in breakroom and hallway.

Webinar 5 Action Plan: More personalized day to day engagement according to their preferences by all.

Webinar 6 Action Plan: Music one-to-one starting with music professional coming as volunteer. Suggest going into detail and on care plan. Also doing much more outside. Will pursue lavender on the person with nursing team.

Webinar 7 Action Plan: Going to make schedules more individual to the person, not the institutional schedule. Food gets cold so will look into open dining times. Will start again with breakfast and move to lunch and dinner.

Webinar 8 Action Plan: requested several times with no response.

Webinar 9 Action Plan: requested several times with no response.

Webinar 10 Action Plan: The pet peeves; asking residents "What bothers you?"

Webinar 11 Action Plan: LOVE the T-shirts! Also, the basketball hoop was an awesome idea/approach – we will be implementing these.

Webinar 12 Action Plan: Working on open dining, getting it up and running again to then be able to support sleep until your body wakes.

Medical director involved 5 days/week plus monthly QAPI, completely 100% onboard. Best practices learned into competency- based education via performance-based quality system, before Gold. **The Power of One: Outcomes Need Everyone. All parties are involved. Empowered. Establish Matter. Execute or Do Over. Information will be shared with the larger team during shower room huddle, postings, emails text messages, town hall, constant communication. We do meetings only b/c we have to.**

Success stories: Qtr. 1: **The Power of One mentioned above has brought great outcomes including low turnover to OC of Venice. Everyone has a voice. We don't do QAPI monthly, we do it every day. Example: a resident was falling, CNA shared it was ever since he got new slip-on shoes. Shoes changed immediately and no falls. Stars then given to team members. STAR = Staff That Achieve Recognition. Team members rewarded and recognized**. Qtr. 2: **Falls are down, engagement and movement really took off. An iPad has changed a resident, got her an account for music and "she loves it". Team on heightened alert for Gold level Baldridge award. Expanded recognition and have given first award *to a resident* Changed Staff to Someone That Achieves Recognition STAR award. Plan to invite residents and family members to become volunteer visitors checking in with residents and learning 4 Ps and an E and intentionally using them to help prevent falls. Referring to ideas and suggestions**

**rather than asking for grievances. Inviting to be part of the solutions. Come up with good ideas. Reframed, not our opponent, we're teammates. Not complainer.** Qtr. 3: Resident's idea Freaky Friday where breakfast is served all day! One day brought in 5 air fryers and made French fries You would have thought we gave a million dollars they were so happy. Gladly giving naps when one wants one, naps are underrated and no longer labeling one "bed seeker." People are hungry, specific snacks, butter pecan ice cream, Uncrustables, Campbell's soup, etc. Qtr. 4: **Falls are down because we focused on pre-fall prevention and being creative. Falls up when we have agency staff however do have them sign off on the 4Ps and an E. Do an initial orientation talking about falls and monitoring, could you do that? Yes, I could. Is the response. The housekeeper cannot be underestimated**. More meaningful approached for individuals. **Sort of like PPE… PPPPE!** When falls were down it was b/c we were being more individualized. For one person we ensured personal items were in front of her esp. her tissues. Also had a room with a view. Told us I've always had nice flowers. She loved planting flowers. So have flowers for her, and a birdfeeder and bath and she got excited. Another resident will sit and look at the fish tank in the living room endlessly. We expanded on meaningful engagement. Now do individualized snack. **A resident was a lumberjack who had ice cream every evening, got if for him, no falls since**. **Other outcomes have been antipsychotics have decreased, resident satisfaction is up, they are happy to see "jazzy snacks". Have a story where a team member could not pick up another shift b/c of her puppy, so administrator invited her to bring it and one resident dog sits and no longer tries to get out of her chair**. In conclusion, it has struck me hard the institutional stuff we do like check/change every 2 hours. Up to use the bathroom they can't stand us waking them up, we were following the institutional approach. Also, the value of increasing connectedness, one of the seven domains of well-being. **Before covid never really thought about keeping connected, non-verbal, I have your son's phone number, she lit up like a candle**. **It hit me they can't pick up the phone, but we can. Want to call your daughter? Without a scheduled meeting or Facetime. Family hadn't thought about that. Nice to get a random call. W woman with six kids, every afternoon called. Sent a message to son and he replied over text she was astounded by this. So, we/I will do it random/ spur of the moment, "Let's call Tony." One time he was at a Chicago White Sox game, and she had never seen this, she was so happy.**

Self-assessment tally of proactive practices from 1 to 22 (of 28).

Psychoactive meds 4.71 to 1.96
Prevalence of falls 38.26 to 27.69
Experiencing one or more falls with major injury 3.3 to 1
High risk pressure ulcers 2.16 to 2.13
Frequently or always incontinent 71.23 to 42.86
Improved performance transfer/locomotion and walking from 64.93 to 72
Percent of residents who made improvements in function short stay 64.93 84.26
Percent of residents whose ability to move independently worsened long stay 28.94 to 23.65

**Fall average decreased 13.6/month to 11.07/month.**
In 4 of 12 months, falls did decrease.

| **Atlantic Shores** | (July 2021) | Aug. 2021 | Sept. 2021 | Oct. 2021 | Nov. 2021 | Dec. 2021 | Jan. 2022 | Feb. 2022 | Mar. 2022 | Apr. 2022 | May 2022 | June 2022 | July 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of falls | 24 | 27 | **20** | 33 | 39 | **25** | **22** | 29 | **27** | 27 | **11** | 20 | Not sub. |
| Number of residents who fell | 22 | 26 | 16 | 20 | 23 | 17 | 19 | 21 | 18 | 16 | 7 | 15 | Not sub. |
| Number of falls w/ injury | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | Not sub. |

**Atlantic Shores Nursing and Rehab**

Contact: Ray McCall, Administrator

4251 Stack Blvd., Melbourne, FL 32901 321-953-2219

Webinar 1 Action Plan: Updating and including more person-centered choice and preferences regarding habits, etc.

Webinar 2 Action Plan: Choosing 1 resident to focus on anticipation of needs, incorporating 4 P's & an E, Education to dept managers

Webinar 3 Action Plan: Roll into care conference resident preferences for personal items and bathroom needs.

Webinar 4 Action Plan: Increase purposeful checking in with residents, outdoor activities, Guardian Angels. Also roll out superpower of being proactive with capes and posters, announce contest, etc.

Webinar 5 Action Plan: Start with resident Esther and “go crazy” with ideas for engagement.

Webinar 6 Action Plan: Team working to catch up, change in administration, active covid, many staff openings.

Webinar 7 Action Plan: was no leadership team

Webinar 8 Action Plan: was no leadership team

Webinar 9 Action Plan: was no leadership team, have now watched Web. 10 though

Webinar 10 Action Plan: More intentional as a team to ensure individual are on care plan and followed.

Webinar 11 Action Plan: Liked some of the activity ideas that were more "grown up" gardening and music.

Webinar 12 Action Plan: Administrator no longer working at this building and no other team member was involved d/t covid struggles.

Medical director involved in webinars and through the QA process. Best practices learned into competency--based education via continued education and apply program to daily operations and practices. Information will be shared with the larger team via group education, TextEmAll platform, huddles.

Success stories: Qtr. 1: **"Check on people when the lights are not on."** Amy Patrick ED. Qtr. 2: Plan to resurrect the trophy which is passed to whichever neighborhood has least number of falls. Qtr. 3: **Utilize a 3 min. hand massage as well as the lavender lotion which combined with human touch and gives a 3 in 1 gift**. Qtr. 4: Falls were down in May because we focused on pre-fall prevention ideas and being creative. Falls were up for June because several stable nurses left, and we had agency nurses who are less familiar with the people who live here.

In 5 of 11 reported months of falls, falls did decrease.
Average number of falls increased slightly from 24 to 24.8 falls per month.
QM and Self-Assessment data was not completed or turned in, administrator turnover and not there at end of project.

**4. Webinar survey results**
Scale of (low) 1, 2, 3, 4, 5 (high) was used.

<u>Webinar 1</u>
Was this webinar educational? Average = 4.5

Was this webinar inspirational/motivational/encouraging? Average = 4.3

<u>Webinar 2</u>
Was this webinar educational? Average = 4.6

Was this webinar inspirational/motivational/encouraging? Average = 4.5

"I think your video is informative, engaging, and productive!"

<u>Webinar 3</u>
Was this webinar educational? Average = 4.6

Was this webinar inspirational/motivational/encouraging? Average = 4.6

"Thank you for another great informational session."

"A lot of those webinars point out things we don't think about." "Good, good ideas you are giving us to think about."

Webinar 4
Was this webinar educational? Average = 4.6

Was this webinar inspirational/motivational/encouraging? Average = 4.6

"Truly enjoyed last webinar, the facts you gave, to think outside the box."

Webinar 5
Was this webinar educational? Average = 4.7

Was this webinar inspirational/motivational/encouraging? Average = 4.8

"Found ideas very helpful and affordable."

Webinar 6
Was this webinar educational? Average = 4.6

Was this webinar inspirational/motivational/encouraging? Average = 4.6

Webinar 7
Was this webinar educational? Average = 4.7

Was this webinar inspirational/motivational/encouraging? Average = 4.7

Webinar 8
Was this webinar educational? Average = 4.7

Was this webinar inspirational/motivational/encouraging? Average = 4.7

Webinar 9
Was this webinar educational? Average = 4.7

Was this webinar inspirational/motivational/encouraging? Average = 4.7

Webinar 10
Was this webinar educational? Average = 4.8

Was this webinar inspirational/motivational/encouraging? Average = 4.8

Webinar 11
Was this webinar educational? Average = 4.9

Was this webinar inspirational/motivational/encouraging? Average = 4.9

Webinar 12
Was this webinar educational? Average = 4.9

Was this webinar inspirational/motivational/encouraging? Average = 4.9

**Project successes and failures**

Results Measurement Successes

Of the 15 homes, 3 saw average number of falls decrease:
1. Orchid Cove of Naples 11.25 to 8.83 falls per month.
2. Orchid Cove of Stuart slightly 20 to 18 falls per month.
3. Orchid Cove of Venice 13.6 to 11.07 falls per month.

A Self-Assessment tally of Proactive Practices to Prevent Falls was developed for this 3rd year. There were 28 practices. Some homes never submitted pre and/or post assessments and the most notable homes with improvement were:
1. Anchor Care 0 to 22 proactive practices.
2. Balanced 0 to 20 proactive practices.
3. Orchid Cove of Venice 1 to 22 proactive practices.

Of the 12 months of the project, the number of times/months falls decreased was tracked:
- 8 months falls decreased at Orchid Cove of New Port Richey
- 7 months falls decreased at Orchid Cove of LaBelle
- 6 months falls decreased at 4 homes Orchid Cove of Dade City, Orchid Cove of Daytona, Orchid Cove of Naples, Orchid Cove of Oldsmar

Of the 12 months of the project, the num er of times a resident fell, and it resulted in a major injury such as a fracture was also tracked:
- One home, Orchid Cove of Dade City experienced ZERO major injuries from falls.
- Three homes, Orchid Cove of Kissimmee, Orchid Cove of Longwood, and Orchid Cove of Oldsmar only experienced only 1.
- Two homes, Orchid Cove of Venice, and Orchid Cove of Daytona experienced only 2.

Pertinent Quality Measures were asked of homes pre and post project. Some were unable to submit but of those that did, the most profound improvements were the following.

Orchid Cove of Dade City:
- Psychoactive meds 67.6% to 5.34%
- High risk pressure ulcer 17.6% to 13.3%

- Percent ability to move worsened 41% to 29.5%

Orchid Cove of LaBelle:

- Psychoactive med. use (long stay) 2.58% to 0%

Orchid Cove of New Port Richey:

- Psychoactive med use 10% to 7 %
- High risk pressure ulcers 22.92% to 15.20%
- Improvements in function short stay 77.38% to 85.1%
- Ability to move worsened long stay 27.89% to 16.8%

Orchid Cove of Stuart:

- Decreased use of anti-psychotic meds 62% to 31.6%
- Psychoactive meds use long stay 15.9% to 5.1%
- Experiencing one or more falls with major injury 3 to 2.49
- Decreased number of pressure ulcers 10% to .82%
- Decreased incontinent episodes 88% to 71.11%
- Frequently or always incontinent 72.2% to 45%
- Improved performance transfer/locomotion and walking 22% to 73.84%
- Percent residents' ability to move independently worsened long stay 24% to 11.5%

Lessons Learned:

- Although times are difficult and some homes have not been able to hold calls due to staffing challenges, the 15 teams' commitment is to be commended with the pandemic ups and downs. No homes dropped out. This is truly amazing.
- Teams did request a packet of information to use for face-to-face team training/ short huddles thus more posters/handouts were created to accompany webinar content. However, not sure if homes have used them that much. In a next project will actually instead require teams to use them more proactively every month.
- One lesson learned/idea realized is that monthly calls instead of every other month would keep the proactive practices on the forefront of teams' minds with so many things happening. Many confirmed this.
- Along those lines, have realized that instead of asking each team what action plan they will do, we will try instead to tell them what practice to implement and if they have another adjacent practice, that is fine but will try a different approach of agreed-upon action plans just to see if ensuring these practices are implemented reduces falls better.
- No home saw falls decrease every month in this particular project sadly it was probably to be expected but with covid and loss of staff and having to use agency staff, this took a toll on total falls. It is true when you see a stable team work together and implement proactive practices, falls decrease. This was stated by many in the project

month after month: if falls were increased you would hear well, we have 50% agency in the building; or if falls decreased, they would say we have stable staff again and/or we have really focused on these simple techniques and using them and reducing falls.

If such simple approaches can be learned and implemented and quality of life improved for people living in nursing homes, let's continue to teach them!

Thank you to the Florida State Survey Agency and CMS Region IV/Atlanta for approving and supporting this 3-year grant.

Submitted by Carmen Bowman, Edu-Catering, Project Coordinator