

# Caring for the Ages

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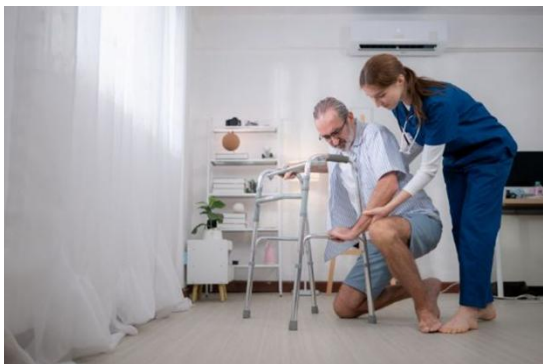


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## A Fresh Look at Falls: Updated Definitions and Requirements for Documentation and Assessment

By Joanne Kaldy

Over [14 million older adults](#) report falling every year, and these falls often result in injuries, some of them serious. Post-acute and long-term care facilities have long focused on fall prevention, but the recently revised LTC Surveyor Guidance includes changes that impact how teams define, manage, and document falls. Updated tools, resources, and training can help ensure that everyone is aligned and there are no gaps in communication or documentation.



### Revised Definitions

The [Minimum Data Set \(MDS\) 3.0 Resident Assessment Instrument \(RAI\) manual](#) (section J) contains revised definitions for falls, which went into effect in October 2025. Falls are defined as “an unintentional change in position coming to rest on the ground, floor, or next lower surface or the result of an overwhelming external force [such as being pushed].”

At the same time, falls now include intercepted or near falls, where someone starts to fall but stops themselves, or is caught by someone else. An anticipated intercepted fall as part of supervised balance training isn’t considered a fall. However, if the person loses balance and actually lands on the ground, floor, or next lower surface during this training, that is defined as a fall and should be documented as such.

The manual also includes an updated definition for fall-related injuries that include skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains, or any injury resulting from the fall that causes pain. An updated definition for major injury includes traumatic bone fractures, joint dislocations/subluxations, internal injuries, amputations, and/or spinal cord, head, and crush injuries. For coding purposes, confirmed pathological injuries – versus traumatic ones – are not considered fall-

related major injuries. The manual includes two new examples addressing the difference between pathological and traumatic fractures.

These changes are significant. Leah Klusch, RN, BSN, FACHCA, executive director of The Alliance Training Center, noted, “The definition of what is considered major injury has been the same for many years. It’s now been enriched with a great deal of additional information, and the definitions are more clinical.” She added, “We have to make sure to communicate these new definitions and guidance with physicians, nurse practitioners, key leadership people, and others to make sure everyone is on the same page and using the updated definitions.”

The medical director needs to be educated about the numerous new coding instructions in the RAI manual regarding what constitutes a fall and what is considered a fall with a major injury.

### **Definitive Documentation**

A key part of documentation is the incident report. Ideally, these will detail how the fall happened, what, if any, injuries resulted, and what interventions took place, such as the resident was examined, suspected of having a fracture, and transported to the hospital; or the resident was examined, and no serious injuries or pain were detected, and the resident stayed in the facility.

Unfortunately, said Ms. Klusch, the incident report is often incomplete for a variety of reasons. These may include the form not being readily available, the instructions being vague, or the reporting nurse being rushed or in the process of a shift change. She suggested that incident report forms need to be conveniently located, including an electronic version that nurses can access with one click.

If a staff member or practitioner witnesses a fall, documentation should include detailed information. For instance, said Ms. Klusch, “It’s not enough to write that the resident fell and hit her head. How did she fall? Did she trip or slip? Did she feel dizzy and lose her balance? And how did she hit her head? Did her head hit a table as she fell? Or did her head hit the floor when she fell?” There needs to be enough detail to give the surveyor or others who read the documentation a clear picture of what happened.

If no one witnesses a fall, Ms. Klusch said, the first thing the team member should ask is, “Do you know how you got on the floor? What do you remember about what happened?” She added, “If we don’t ask these questions as soon as the fall is discovered, it’s harder to go back and reconstruct this later.”

“It’s important to know what happened and to document it accurately so that when you get your report on quality measures related to falls, you can be confident that the data is correct and precisely reflects what happened with each incident, particularly falls with major injury,” Ms. Klusch said.

### **Reliable Resources**

It is important to have reliable resources that the care team can use. Among these is the recently revised PALTmed Falls and Fall Prevention in the Post-Acute and Long-Term Care Setting . Amanda Lathia, MD, CMD, an Ohio-based geriatrician who was part of the workgroup that worked on the revision, said, “We included more in the definition of falls compared to the previous version. It emphasizes the revised definitions, including the fact that a near or intercepted fall is considered a fall.” The document outlines

each component of a fall, beginning with the assessment. It also ties in the Age-Friendly Health initiative and the 4Ms framework (What Matters, Mobility, Mentation, and Medication).

It is also important for team leaders and others involved in resident assessments to read the section about falls in the most recent version of the RAI manual. It will also be useful to have the revised definitions and guidance readily available. For instance, they might be attached to or included on the incident report form and/or posted at nurses' stations.

### **The Art of Accurate Assessments**

The revisions regarding falls, said Dr. Lathia, should prompt a medical director to work with the facility to review and revamp their policies, procedures, and assessment tools to ensure they align with the information in the RAI manual.

For instance, she said, "At my facility, we are revamping our assessment tool so that it's much more detailed and goes through much of what is described in the PALTmed CPG." She added that it is useful to have a tool built into the facility's electronic health record that prompts an assessment when a fall occurs.

"We need to be using these resources to educate our teams, and that's what I plan to do at my facility [this year]. Education will help enable true, in-depth assessments and the confidence that every team member knows their role," said Dr. Lathia.

### **Prioritizing Prevention**

While the care team focuses on managing, reporting, and documenting falls, it is also important not to overlook proactive risk assessments. For instance, as Steven Buslovich, MD, MS, CMD, chief medical officer at PointClickCare, said, "You could conduct frailty risk assessments to help detect subtle changes in condition through identifying functional cognitive and psychosocial deficits that the resident or the individual may have acquired since the prior evaluation. This can help you care plan better to address those deficits as part of falls prevention efforts."

Dr. Buslovich added, "Most of our care planning is done around diagnoses, and we need to evolve into a frailty-driven care planning approach, which is much more holistic and patient-centric." He suggested that having a "cookie-cutter approach to diagnosis management doesn't work if you don't contextualize the individual's underlying degree of frailty and their propensity for improvement or potential harm."

### **Data Tells a Tale**

"It is important to know that CMS will now look at information in claims files for older adults who have fallen," said Ms. Klusch. For instance, they will be looking to see if you sought treatment at the emergency room, hospital, or physician's office where there was another claim generated.

When surveyors enter the building, they will closely examine what was done after the fall and why. For instance, if the resident was sent to the ER after a fall but didn't have a major injury, they will want to know the reason for the transfer. They will be looking to see that falls were documented and that any injuries are coded accurately.

This goes back to the initial assessment after a fall, Dr. Lathia noted. It is essential to get as much information about the fall as possible and assess the patient for possible injuries that require X-rays or further examinations and treatment not available in the facility. A fall doesn't immediately mean a trip to the ER, she explained; this is a clinical decision that requires input from the physician, nurse practitioner, or physician associate. CMS and surveyors will be looking for possible overuse or inappropriate use of the ER.

Dr. Lathia said, "This is another place where team education and training come in." The medical director can take the lead in educating the team to help ensure that assessments are complete and that residents aren't sent to the ER unnecessarily. She stressed, "This is not solely on the physician but truly requires an interdisciplinary approach. Every team member has a role to play in helping to assess risk for falls, preventing falls, and managing them when they occur."

Dr. Buslovich agreed, adding, "Surveyors often are unaware of the unavoidability of some falls, and our documentation needs to show what we do to assess and mitigate fall risks, how a fall happened, and what we did after a fall to protect the resident."

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<https://paltmed.org/news-media/fresh-look-falls-updated-definitions-and-requirements-documentation-and-assessment>