FSI -- Fall Scene Investigation Report

Facility Name:					
Resident Name:		Med. Rec. #	Room #		
Date of Fall	Time of Fall:	AM / PM	Admit Date:		
Staff / Witness present at / or finding resident after fall:					
FALL DESCRIPTION DETAILS:					
 1. Factors observed at time of fall: Resident lost their balance Resident slipped (give detail) Lost strength/appeared to gweak Wheelchair / bed brakes unlocked Bed height not appropriate Equipment malfunction (specify): Environmental noise Environmental factors (circle write in): clutter, furniture, in out of reach, lighting, wet for other (specify) 	et e or tem	und. (e.g. face down, on l	position in which resident was back / R or L side, position of juipment /devices nearby)		
*If fall within 5 feet of transfer surface do orthostatic BP					
 Fall Summary: Found on the floor (unwitnessed) Fall to the floor (witnessed) Intercepted fall (resident low to floor) Self-reported fall 	ssed)	Dining room/day room Bathroom [CHECK TOIL Toilet contains Shower/tub room Outside building on pre	urine /feces		
5. What was resident doing during fall? Ambulating Attempting self-transfer Transfer assisted by staff Reaching for something Slide out / fall from wheelch Rolling/sliding out of bed Sitting on shower/toilet cha Other (specify):	air	at time of fall? ☐ Assisted per ☐ Alone and u			



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7.	What did the resident say they were trying to de	o just before they fell?			
,,	that are the resident out they have a time to	o just belove they rem.			
	CONTRIBUTING FACTORS TO HELP IDENTIFY ROOT CAUSE OF FALL:				
8.	Describe resident's mental status prior to fall:		osychological status prior to		
0.	2 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -	fall:	or one of the contract of the		
	How does this compare to the resident's usual	How does this compa	re to the resident's usual		
	mental status?	psychological status?			
10.	Footwear at time of fall:	11. Gait Assist devices at	t time of fall:		
	☐ Shoes ☐ Bare feet	☐ None☐ Has device and v	vac in uca		
	☐ Gripper Socks	☐ Has device and v			
	□ Slippers	Tras device but w	ras not in use		
	□ Socks				
	☐ Off load boots				
	☐ Amputee				
12.	Did vision or hearing contribute to fall?	13. Alarm being used at	the time of the fall?		
	Yes	□ Yes			
	□ No Explain:	☐ No If yes, was it working	correctly2		
	Explain.	ii yes, was it working	correctly:		
14.	Time last toileted or Catheter emptied:	15. Did fall occur?			
	AM /PM		surface (assess postural hypotension)		
	Continence at above time:		er surface (assess balance)		
	☐ Wet ☐ Soiled	□ > 15 from trans	fer surface (strength /endurance)		
☐ Dry 16. Medications given in last 8 hours prior to fall (check all that apply):					
	☐ Anti-anxiety	11 //			
	☐ Anticoagulant				
	☐ Antidepressant				
	☐ Antipsychotic ☐ Cardiovascular				
	Diuretic				
	☐ Laxative				
	□ Narcotic				
	Seizure				
	☐ New meds/changed dose within last 30 days				

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17. Vital Signs: Were temperature, pulse, respirations and/or O2 Sat out of normal range for this resident? Yes No Did orthostatic BPs suggest the BP change contributed to the fall? Lying Yes Sitting No Standing Re-Creation of Last Below, the primary Nursing Assistant who observed and /other fall will write a description to re-create the life of the interpretation.					
PRINT NAME:					
Re-enactment of fall (to be done if Root Cause is NOT determined):					
Fall Huddle (What was different THIS time?)					
DOOT CALLSE					
	ROOT CAUSE OF THIS FALL: Review of Contributing factors (Check all that apply):				
Alarm Amount of assistance in effect Assistive/protective device Environmental factors/items out of reach Environmental Noise Footwear Medication					



FSI -- Fall Scene Investigation Report Facility Name: Med. Rec. # _____ Room # ____ Resident Name: What appears to be the initial root cause(s) of the fall? Describe initial interventions to prevent future falls: ☐ Care Plan Updated ☐ Nurse Aide Assignment updated **NURSE COMPLETING FORM:** Date and Time: Printed Name: _____ Signature: Falls Team Meeting Notes: Summary of meeting: Systemic or operational conditions that may contribute to falls? Any patterns or trends to the residents' falls? Conclusion: Additional Care Plan / Nurse Aide Assignment Updates: Signatures with Date and Time:

