FALL INVESTIGATION REPORT

Resident Name: ________________________________ Age: _____ Room #: ______ Date/Time of Fall: _______________

Resident Medical Diagnoses: ____

____

NURSING REVIEW:

Does resident have a history of falls? YES NO Previous fall dates: ____

Does resident have postural hypotension? YES NO Describe: ____

Record Blood Pressure & Pulse (wait 2 minutes in each position before taking measurement):

Supine:_____/______ mm Hg _____bpm Sitting:_____/_____ mm Hg _____bpm Standing:_____/_____ mm Hg _____ bpm

Date of most recent lab results: _____________ Findings: ____

Does resident exhibit signs / symptoms of acute illness? YES NO Describe: __________________________________

Does resident have impaired cognition/judgement/memory? YES NO Describe: __________________________________

Does resident have impaired safety awareness? YES NO Describe: __________________________________

Does resident have a history of pain complaints? YES NO Describe: __________________________________

Has resident had a recent change in behaviors? YES NO Describe: __________________________________

Has resident had a recent change in mental status? YES NO Describe: __________________________________

Is resident continent? YES NO Does resident toilet self? YES NO Describe: __________________________________

Is resident on a bowel and bladder program? YES NO Describe: __________________________________

Describe resident's vision: ADEQUATE POOR Glasses? YES NO Functional Vision Screen Completed? YES NO

Describe resident's hearing: ADEQUATE POOR Hearing Aids? YES NO Describe: ___________________________

Has the resident experienced any recent weight loss? YES NO Describe: __________________________________

Does resident use oxygen? YES NO Describe: __________________________________

Have there been any recent environmental changes? YES NO Describe: __________________________________

Can resident manipulate call light? YES NO Describe: __________________________________

Is resident ambulatory? YES NO Describe: __________________________________

Does resident use a wheelchair? YES NO Describe: __________________________________

Does resident have a specialty bed? YES NO Describe: __________________________________

Is resident restless in bed? YES NO Describe: __________________________________

Does resident have a restraint ordered? YES NO Describe: __________________________________

Does resident have a safety device ordered? YES NO Describe: __________________________________

PHARMACY REVIEW:

Current Resident Medications: ____

____

Do any of these medications cause sedation or dizziness? YES NO Describe: __________________________________

Are there medications that could contribute to falls? YES NO Describe: __________________________________

Have there been recent medication changes? YES NO Describe: __________________________________

Are most recent lab results within normal limits? YES NO Describe: __________________________________

Could dizziness be present for other reasons? YES NO Describe: __________________________________

SAMPLE

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THERAPY REVIEW:

Is resident currently participating in skilled therapy? YES NO Describe: ________________

Is resident currently participating in restorative program? YES NO Describe: ________________

Does the resident exhibit any significant gait deviations? YES NO Describe: ________________

Are there gait / balance changes associated with head motion? YES NO Describe: ________________

Is the resident utilizing faulty equipment? YES NO Describe: ________________

Are there changes in activity tolerance or deconditioning? YES NO Describe: ________________

SUGGESTED CARE PLAN: ________________

REVIEW COMPLETED BY (IDT SIGNATURES): ________________

________________ DATE: ________________

SAFETY COMMITTEE COMMENTS: ________________

SAFETY COMMITTEE SIGNATURES: ________________

________________ DATE: ________________

MEDICAL DIRECTOR REVIEW: ________________

MEDICAL DIRECTOR SIGNATURE: ________________ DATE: ________________

SAMPLE