



## FSI -- Fall Scene Investigation Report

Facility Name: \_\_\_\_\_

Resident Name: \_\_\_\_\_

Med. Rec. # \_\_\_\_\_

Room # \_\_\_\_\_

7. What did the resident say they were trying to do just before they fell?

**CONTRIBUTING FACTORS TO HELP IDENTIFY ROOT CAUSE OF FALL:**

8. Describe resident's mental status prior to fall:

How does this compare to the resident's usual mental status?

9. Describe resident's psychological status prior to fall:

How does this compare to the resident's usual psychological status?

10. Footwear at time of fall:

- Shoes
- Bare feet
- Gripper Socks
- Slippers
- Socks
- Off load boots
- Amputee

11. Gait Assist devices at time of fall:

- None
- Has device and was in use
- Has device but was not in use

12. Did vision or hearing contribute to fall?

- Yes
- No

Explain:

13. Alarm being used at the time of the fall?

- Yes
- No

If yes, was it working correctly?

14. Time last toileted or Catheter emptied:

\_\_\_\_\_ AM /PM

Continence at above time:

- Wet     Soiled
- Dry

15. Did fall occur?

- Next to transfer surface ( assess postural hypotension)
- 10 ' from transfer surface (assess balance)
- > 15 ' from transfer surface (assess strength /endurance)

16. Medications given in last 8 hours prior to fall (check all that apply):

- Diuretic
- Anti-depressants
- Narcotics
- Anti-anxiety
- Anti-psychotics
- Seizure
- Cardiovascular
- New meds/changed dose within last 30 days



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What appears to be the root cause of the fall?

Describe initial interventions to prevent future falls:

Care Plan Updated

Nurse Aide Assignment updated

### NURSE COMPLETING FORM:

Printed Name: \_\_\_\_\_

Date and Time:

Signature:

### Falls Team Meeting Notes:

Summary of meeting:

Conclusion:

Additional Care Plan / Nurse Aide Assignment Updates:

Signatures with Date and Time: