Facility: Annandale Care Center Welcome, Sondra Behrendt RN [Log off]

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matrix

Messages Resident Facility RAI

Add Observation

[redacted] Full Code

RN

Type: **Post Fall Assessment**

Post Fall Assessment

Description

Observation Date Occurred:	01/26/2010	**Observation Time Occurred:**	10 : 15 AM
Short Description:			

Observation

Witnesses - If the fall was witnessed, list by whom.	
Location Of Fall	○ Day Room ○ Outside On Facility Grounds ○ Dining Room ○ Resident Bathroom ○ Hallway ○ Resident Room ○ Outside Of Facility Grounds ○ Other
Describe, if necessary.	
Detailed Description Of Fall - Be specific, e.g. fell backward/forward; knees gave out; tripped; lost balance; poor trunk control; slid off bed/chair; missed chair; etc.	
What was resident's location prior to the fall?	○ In Bed ○ Transferring ○ In Wheelchair ○ Walking ○ In Other Chair ○ Other ○ On Toilet ○ Unknown
Describe, if necessary.	
Mental Status Prior To Fall	○ Alert And Oriented ○ Lethargic ○ Agitated ○ Resistive ○ Calm ○ Sleepy ○ Combative ○ Other ○ Confused
Describe, if necessary.	

Resident's usual ambulatory status.	○ Independent With/Without Device ○ Assist Of Two + With/Without Device ○ Assist Of One With/Without Device ○ Unable To Ambulate
Was there a deviation from usual status? If so, describe.	
What footwear did resident have on at the time of the fall?	☐ Barefeet ☐ Socks - Regular ☐ Shoes ☐ Socks With Skid Grip ☐ Slippers ☐ Other
Describe, if necessary.	
Restraints/Adaptive Equipment - Were any measures in use at the time of fall, e.g. alarm, side rails, seat belt? If so, describe.	
Does resident take 9 or more medications?	○ Yes ○ No
Does resident receive any of the following types of medications?	☐ Alcohol ☐ Cathartics ☐ Antidepressants ☐ Diuretics ☐ Antiemetics ☐ Hypoglycemics ☐ Antihistamines ☐ Narcotics ☐ Antihypertensives ☐ Sedatives/Hypnotics (Benzodiazepines) ☐ Antipsychotics/Neuroleptics ☐ Other ☐ Anxiolytics ☐ None of above
Describe, if necessary.	
Fall History - How often has resident fallen in last 90 days?	
Is there a pattern to resident's falls? If so, describe.	

INTERVENTIONS	
Medical Care Provided Post Fall	☐ Basic First Aid ☐ Other ☐ Emergency Room Visit ☐ No Care Necessary ☐ Hospitalization
Describe, if necessary.	

EVALUATION	
Summarize potential factors that could have contributed to the fall.	

PLAN OF CARE	

Describe measures to be taken to prevent further falls.	

Additional Information

Additional Info:	

Observation Complete: ☐