Fall Scenario Case Study for LTC Nurses

CMS Compliance Group Discussion

SCENARIO: The Case of Margaret Thompson

Background Information

Resident: Margaret Thompson, 78-year-old female
Admission Date: 6 months ago
Primary Diagnoses: Moderate Alzheimer's dementia, hypertension, osteoporosis, history of UTIs
Current Medications: Donepezil 10mg daily, Lisinopril 10mg daily, Trazodone 50mg at bedtime PRN for sleep, Calcium + Vitamin D supplement

Recent Changes:

- Started on Trazodone 3 days ago due to increased nighttime restlessness
- Complained of feeling dizzy when standing yesterday morning
- Has been asking to go to the bathroom more frequently over the past 2 days

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The Incident

Time: 2:15 AM
Location: Margaret's room (semi-private, she has the bed closer to the bathroom)
Staff on Unit: 2 CNAs, 1 LPN for 24 residents

What Happened: CNA Jennifer was completing her 2 AM rounds when she heard a loud thud from Margaret's room. She found Margaret on the floor beside her bed, sitting up and appearing confused. Margaret stated, "I needed to go to the bathroom, but my legs just gave out."

Immediate Assessment:

- Alert but confused about what happened
- Small laceration on her right forearm, minor bruising on her hip
- Denies pain initially, then reports her hip "feels sore"
- Vital signs: BP 100/60 (baseline 130/80), HR 88, no fever
- No obvious head trauma, but resident cannot recall exactly how she fell

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Relevant Background Details

Fall Risk Assessment: Last completed 1 month ago - scored 45 on Morse Fall Scale (moderate risk)

Care Plan Information:

- Has bed alarm, but CNA reports it "goes off too frequently" and sometimes residents find it annoying
- Ambulates with rolling walker during the day with supervision
- Usually continent but has had 2 episodes of urgency incontinence in past week
- Family reported she's been more confused in the evenings lately

Environmental Factors:

- Room has nightlight, but main bathroom light was out (reported yesterday, work order pending)
- Resident's walker was positioned at foot of bed
- Call light was clipped to bed rail, within reach
- Floor was dry, no obstacles in pathway

Documentation Issues:

- Last nursing assessment documented 3 days ago
- No documentation of dizziness complaint from yesterday
- Bed alarm effectiveness not recently evaluated
- Fall risk reassessment overdue (should be done with medication change)

Discussion Questions

Immediate Response & Assessment (F323 - Quality of Care)

1. What are your immediate priorities for Margaret's care?
2. What assessments need to be completed before moving her?
3. Who needs to be notified and in what timeframe?
4. What documentation is required within the first hour?

Fall Risk Assessment & Prevention (F329 - Accident Prevention)

5. What fall risk factors were present that should have been identified?
6. How should the recent medication change have affected her care plan?
7. What environmental modifications could have prevented this fall?
8. Was the bed alarm system being used appropriately?

Root Cause Analysis

9. What systemic issues contributed to this incident?
10. How did documentation failures impact continuity of care?
11. What role did staffing levels play in this situation?
12. How should the bathroom lighting issue have been addressed?

CMS Compliance Issues

13. Which F-tags are potentially at risk due to this incident?
14. What documentation deficiencies could result in citations?
15. How does this fall impact quality measures reporting?
16. What corrective actions are needed to prevent recurrence?

Communication & Family Involvement

17. When and how should Margaret's family be contacted?
18. What information should be shared with the physician?
19. How should this be communicated to the next shift?
20. What role should the interdisciplinary team play in follow-up?

Key Learning Objectives

By the end of this discussion, participants should be able to:

- **Identify** multiple fall risk factors in complex resident situations
- **Recognize** CMS compliance requirements related to fall prevention and incident response
- **Demonstrate** proper incident response and documentation procedures
- **Analyze** systemic factors that contribute to fall risk
- **Develop** comprehensive fall prevention strategies
- **Understand** the importance of timely reassessment with condition changes

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Regulatory References for Discussion

F323 (Quality of Care): Each resident must receive care that meets professional standards of quality and that maintains or enhances dignity and self-esteem.

F329 (Accident Prevention): The facility must ensure that residents receive treatment and care to prevent accidents.

F385 (Quality Assurance): The facility must maintain a quality assurance and performance improvement program.

F279 (Comprehensive Care Plans): The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet medical, nursing, and mental and psychosocial needs.

Facilitator Notes

- Encourage discussion of both immediate and long-term interventions
- Emphasize the importance of individualized care planning
- Discuss how this scenario could be prevented through better systems
- Address the balance between safety and resident autonomy
- Review actual CMS survey findings related to similar situations