Resident Event Fall Scenario

Resident Data:

Resident is an 81 year old male resident who has resided in the facility for 17 days. He has been admitted from an Acute Care Hospital secondary to a ground level fall that resulted in a right hip fracture with an ORIF repair completed. He was admitted to a Skilled Nursing/Rehabilitation Facility for Physical Therapy and Occupational Therapy for Gait training, and ADL needs. He is Weight Bearing as tolerated. He tends to be impulsive and does not follow hip precautions or call for assist. He lives alone at home and has a daughter that lives close by and visits daily at home and now in the facility. He is fiercely independent. His fall at home occurred while he was working in his yard doing some weeding and his dog ran through his legs, catching him off balance and resulted in the fall. He has poor vision and is hard of hearing. He has a cane at home but refuses to use it per his daughter. He is not good at taking his medications as prescribed and often forgets them.

The resident has the following diagnosis and Medications:

Mild Age Related Dementia
Hypertension:
Cardizem 30 mg PO every day
Coronary Artery Disease/Clot prevention:
Plavix 75 mg PO every day
Gerd:
Protonix 20 mg PO every day
Congestive Heart Failure Chronic with Acute flare up
Lasix 80 mg PO every day:
Surgical and Joint Pain
Vicodin 500/5 mg PO every 4-6 hours as needed for pain
Surgical and Joint Pain
Tylenol 325 mg 1-2 tabs PO every 4-6 hours as needed for pain
Urinary Tract Infection:
Ciprofloxin 250 mg PO QID times 10 days (6 more days left)
Constipation:
Colace 50 mg PO BID

Event:
At 1600 the resident was found sitting on the floor in his bathroom next to the toilet with his back resting against the wall that faces the toilet. The resident's right leg is externally rotated and the resident is yelling out in pain and discomfort at any movement of his body. He is complaining of dizziness and chest discomfort. No complaints of pain anywhere else at present but stated that his legs had been cramping and he became dizzy. He is pale and diaphoretic. He states that he had to go to the bathroom so just got up and walked in there. He did not put his call light on in his room or pull the call light in the

bathroom. His call light is still attached to his bedding on his bed and is functional. The cord to the call light in the bathroom is present but now out of reach. The resident's walker is folded outside the bathroom door and leaning against the wall. The resident's vital signs while sitting are B/P 100/60 Pulse 82 and irregular, Respirations 22, Temperature 100.2. The resident's usual B/P is 140/78 and temperature has been 99.2 earlier in the day. His baseline respirations are usually at 16 per minute. There is urine on the floor at the resident's feet. The resident's oxygen saturation is 88 and oxygen at 2 liters per minute has been started to raise his oxygen saturation rate. 911 has been called secondary to the external rotation and chest pain. Resident is a full CPR. The resident's physician has been notified as well as the resident's responsible party with the resident's permission.

Please use the Root Cause Analysis investigative tool in determining the steps to success in investigating this event.