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MDS Alert

Case Study: Dig Deep To Get To The Bottom Of A Fall

Taking the right steps in time can protect your residents and survey record.

When a resident fall lands a facility with an F tag, you need a heads-up on whether the incident is an isolated one - or a systemic shortfall that somehow escaped the QA radar screen.

Case in point: A resident's fall and injury triggered a complaint survey resulting in an F324 D-level tag, reports **Laura Ferrara, RN, MSN**, formerly corporate director of clinical services for a nursing home chain in Grand Rapids, MI.

The resident in question fell out of bed when she tried to get up without assistance at night, lacerating her forehead. The woman required eight sutures to close the wound, Ferrara related in a case study presentation at the most recent **American Health Care Association** annual convention in Miami.

The facts: The resident, who had a diagnosis of Alzheimer's-related dementia, had developed pneumonia on April 23 and was still receiving antibiotic treatment when she fell on April 30.

At 2 a.m., the nursing staff found the resident face down on the floor, reported Ferrara.

MDS Shows Diagnoses, ADL Requirements

Surveyors investigating the fall looked at the MDS and found the resident had the following problems:

1. Anxiety and Parkinson's disease coded in Sections E and I;
2. Problems with long- and short-term memory;
3. Moderate impairment in daily decision making coded at B4;
4. Received extensive assistance for bed mobility (Section G);
5. Staff had coded the resident as being completely dependent for other ADLs.

The resident got up by herself, so something went wrong in that she didn't get assistance, notes Ferrara.

Care Plan Reveals Safety Measures

Another problem: Surveyors found the staff had not updated the resident's care plan for some time.

On the positive side, the care plan included several safety measures to prevent falls and fall-related injuries. These included the following interventions:

1. Keep a mat on the floor by the bed (to break falls);

2. Provide a safety mattress for the bed;

3. Maintain an alarm in the bed and chair when the resident is in both locations to alert staff when the resident attempts to get up unassisted.

Staff knew they were supposed to pull the floor mat up to the head of the bed, but the oxygen tank was in the way.

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In addition, "the tab alarm was on the wrong side of the bed, which is why it didn't go off when the resident tried to get up on her own," Ferrara told **Eli.**

The nurses could have pulled the mat up to the head of the resident's bed to break her fall - if they had simply obtained longer oxygen tubing so they could reposition the oxygen tank.

"So a simple fix could have prevented the resident's injury," Ferrara says. Thus, at first glance one might conclude the fall-related injury was a one-time event resulting from failure to implement the care plan.

The million-dollar question: Did the problem causing the fall really reflect a systemic issue, thereby setting the facility up for additional falls, F tags and potential lawsuits? (For the answer, read the "rest of the story" on p. 78.)

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