STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105453	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENSINGTON GARDENS REHAB AND NURSING CENTER	**2055 PALMETTO ST CLEARWATER, FL 33758**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (Resident #2) of five residents sampled for falls received the supervision required to prevent three falls in 18 days and sustaining a fall on 9/26/20 that required surgery for [REDACTED]. Resident #2 fell six times from 7/4/20 to 9/26/20 requiring two transfers to the hospital. The facility failed to investigate the root cause of the falls for Resident #2 to ensure adequate interventions and supervision were in place. Findings Included: Review of Resident #2's hospital record revealed a History and Physical dated 9/27/20 with a chief complaint of fall at facility. The History of present illness was a [AGE] year old lady admitted to hospital secondary to trip and fall. Patient not able to provide much history, suspected significant dementia present. Patient is disoriented to place and person. Review of chart showed the patient was brought in after a fall with laceration to head complaining of right hip pain. Work up done seems non-syncopal x-rays revealed patient to have right femoral neck fracture. A CT of head was negative for acute finding .Patient has been seen by orthopedic surgeon and taken to the OR (operating room) for arthroplasty. Review of the accident and incident log documented Resident #2 sustained falls on: 9/26/20 at 7:19 p.m. in her room sustaining a laceration and [MEDICAL CONDITION] sent to the emergency room resulted in [MEDICAL CONDITION] and laceration. 9/12/20 at 5:11 p.m. in her room without injury. Intervention added, place resident in wheelchair for all meals. 9/9/20 at 3:30 p.m. in her room without injury. Intervention added, floor mats. 8/15/20 at 3:47 p.m. in the hallway of the South wing sustaining a Hematoma, sent to the emergency room . Intervention added, Broda chair. 8/8/20 at 8:30 a.m. in her room without injury. Intervention added, offer toileting after breakfast. 7/4/20 at 2:00 p.m. in her room sustaining laceration to the left eyebrow treated in house. No interventions documented. On 10/13/20 at 4:05 p.m., the Director of Rehab stated Resident #2 was on occupational therapy, physical therapy, and speech therapy (OT, PT and SP) until 9/25/20. The resident could ambulate but was not steady. She was ambulating up to 75 feet with minimum assistance using a rolling walker. She was transferring with contact guard assistance and stand by assist for bed mobility. Safety awareness was an issue due to cognitive deficits. She should never have been up in her room unsupervised. We have weekly meetings that go over resident recommendations with nursing staff. After she was diagnosed with [REDACTED]. On 9/25/20, Resident #2 improved from 75 to 90 feet which improved up to minimum assistance with the therapist providing up to 25% assistance for the resident's weight. Resident #2's cognitive deficit was very low. She was unable to understand and redirect. Review of the facility documents and fall investigations related to Resident #2 with the Assistant Director of Nursing (ADON) on 10/13/20 at 1:36 p.m. revealed Resident #2 fell on [DATE] at 7:19 p.m. after staff completed care and the resident's eyes were closed. The staff left the room and heard a thud. The ADON provided copies of the fall investigations, which did not describe any of the information the ADON was providing. The ADON said falls were discussed in the morning meeting as a team to look for trends, to see what is not working, and come up with a plan from there. It's the entire interdisciplinary (IDT) team at the morning meeting, which includes the ADON, Director of Nursing (DON), Nursing Home Administrator (NHA), Unit Managers, the therapy department, and the Case Manager. The ADON stated she did not have any documentation related to a root cause investigation for the six falls sustained by Resident #2. The ADON stated she does ask the staff if they saw the resident and gets a statement to see what happened. According to the ADON, she only got one witness statement for the 9/26/20 fall and had no other witness statements for Resident #2's five other falls. A review of the one statement the ADON had related to Resident #2's fall on 9/26/20 was from the CNA assigned to her care. The CNA reported that she had just cleaned, toileted, and placed the resident in bed, when she left the room to answer another resident's call light. She heard a resident holler that Resident #2 was in the hallway by the door with her head bleeding. The aide stated that Resident #2's mats were down by her bed and the bed was in the low position when she left the room at 1900 hours (7:00 p.m.). Review of the skilled documentation dated 9/26/20 at 6:37 a.m. for Resident #2 reflected: primary [DIAGNOSES REDACTED]. Speech clarity checked for unclear speech-slurred or mumbled words. Ability to understand others checked as sometimes understand-responds adequately to simple, direction communication only. Cognition documented as inattention and disorganized thinking. Urinary incontinence checked as always incontinent. Current toileting program or trial checked as NO. Musculoskeletal checked as not steady, only able to stabilize with staff assistance. Moving on and off toilet checked as not steady, only able to stabilize with staff assistance. Surface to surface assistance (transfer between bed and chair or wheelchair) checked as not steady, only able to stabilize with staff assistance. Currently receiving therapy for PT, OT and SLP/ST. Summary reflected resident ambulates on occasion with unsteady gait noted. The documentation included a summary of, Resident A & O (alert and oriented), no S/S (signs or symptoms) of distress, voices needs, ambulates on occasion with unsteady gait noted, fluids enc (encouraged), call light in reach, will continue to monitor. Review of the Situation Background Appearance Review and Notify (SBAR) communication form dated 9/26/20 at 7:00 p.m. reflected Resident #2 sustained a fall. Pain checked as not clinically applicable to the change in condition being reported. Recommendation to send to the emergency room for further evaluation. Review of the facility document dated 9/26/20 at 7:19 p.m. revealed a nursing description of, resident up walking in room and found lying on the floor by the door with head on floor with laceration to back of head. The resident description was noted as, Resident Unable to give description. Immediate actions taken were: Resident assessed, treatment applied to stop bleeding. Physician notified and order to send to the emergency room . Intervention: medication review. Injury type: laceration to back of head. Predisposing psychological factors checked as confused, gait imbalance, impaired memory, and fragile/sensitive skin. Review of the fall risk evaluation dated 9/26/20 at 7:19 p.m. reflected cognition checked as behavior not present and no evidence of acute change in mental status. History of falls was checked yes. Ambulation in relation to elimination status checked as non-ambulatory and requires staff assistance with elimination. Walking and turning around checked as not assessed. Fall risk score of 6. Determination reflected a score of 10 or above represents high risk. Initiate a fall risk care plan for high risk components regardless of resident not scoring a 10 or above. Review of the physician progress notes [REDACTED]. She has been observed sitting in her wheelchair at the nurses station. Diagnosis/plan: 7. Fall: Nursing to increase rounding. Patient to be up in wheelchair for all meals. 9. Altered Mental Status(AMS): She has returned to her baseline confusion. Nursing to monitor for increased AMS. During an interview with the ADON on 10/13/20 at 1:36 p.m., she stated Resident #2 sustained a fall in her room on 9/12/20 at 5:11 p.m. and was found on floor, lying on her left side next to the bed with her legs and arms out with her back to the bed and head lying on floor. Response appropriate and at baseline. Patient reported hitting her head. The floor mats were down according to the ADON's statement. The ADON was unable to provide documentation to show that the floor mats were down. Intervention put in place was up to wheelchair for all meals per the ADON as her dinner tray was on the bedside table. The ADON stated she was unsure of what happened and when the resident was last toileted or seen and could not provide documentation and stated the team included the intervention due to the dinner tray sitting at the bedside table.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) The ADON said the cause of the fall was unknown and unwitnessed. The ADON said, before the resident tested positive for COVID-19, the resident was always up with staff and up for meals. The ADON stated she was given activities and stated we had difficulty keeping six feet apart. The ADON stated, I feel the interventions are appropriate to try to keep her safe. It's not documented the last time she was seen, toileted or if the fall mats were down. The aides were outside the room. Review of the facility document dated 9/12/20 at 5:11 p.m. provided by the ADON reflected, aid retrieved this nurse to report pt was found in floor beside her bed. Nurse immediately assessed pt. Pt was observed to be on her left side, legs extended, with arms out, back to her head, with head lying on the floor. Pt responses appropriate and baseline, pt reports having hit her head, no immediate bruising noted or observed, no redness or swelling noted. Pt observed wearing appropriate footwear. Pt was continent at time of fall. dinner tray on bedside table. Nuero checks within normal limits and stated she cannot remember. There is some redness on her inner right arm, when asked what happened here she stated she thinks she hit the table when she fell . No reports of pain at this time. No apparent injuries noted. Range of motion in all four extremities. Pt assisted to her bed and then wheelchair to dining room with staff. Description: Pt stated she was trying to get up but cannot remember why. Pt denies pain. Pt states she did hit her head. Immediate action taken- Historical reports reviewed of patients previous falls, a trend is noted that she is most often falling between the times of 2:00 p.m. and 5:00 p.m. with outliers in the morning. It is probable from this trend that patient is falling during dining times and the most appropriate action at this time would be to have patient up in wheel chair in dining room for all dining times. Awaiting on call physician call back to see if psych eval or urinalysis is needed. Intervention: Resident up in wheelchair for all meals. Predisposing physiological factors checked as confused, gait imbalance, impaired memory, incontinent, and weakness/fainted. Predisposing situation factors checked as ambulating without assist. Review of the nursing progress notes dated 9/12/20 at 5:11 p.m. reflected aid retrieved this nurse to report pt was found in floor beside her bed. Nurse immediately assessed pt. Pt was observed to be on her left side with head lying on the floor. Review of the physician progress notes [REDACTED]. She was observed sitting in her wheelchair at the nurses station. General: mildly lethargic, cooperative and conversive in no acute distress. She is sitting upright in bed, appears comfortable. Diagnosis/plan: 7. Fall: nursing to increase rounding. Patient to be up in wheelchair for all meals. Review of the fall risk evaluation dated 9/12/20 at 9:29 p.m. reflected the resident cognition checked as behavior present, fluctuates. Resident checked as having falls. Ambulation in relation to elimination status checked as ambulatory and incontinent. Walking checked as activity did not occur. Moving on and off toilet checked as not steady, only able to stabilize with staff assistance. Fall risk score total of 13. Total score above 10 represents high risk. Review of the facility document dated 9/9/20 at 3:30 p.m. provided by the ADON reflected Resident found in the floor at 3:30 p.m. Resident can not recall how this happen. Immediate action taken- Assessed, FROM noted x 4 extremities, Intervention: floor mats. Mental status checked as alert with periods of forgetfulness, oriented to person. Predisposing physiological factors checked as gait imbalance and impaired memory. Review of the nursing progress notes dated 9/9/20 at 1:44 p.m. reflected the resident alert with confusion, currently in bed with head of bed up. All needs met by staff. Review of the nursing progress notes dated 9/9/20 at 6:05 p.m. reflected the resident status [REDACTED]. Low airloss mattress in place, bed in low position, call light in reach, all needs met by staff. Review of the skilled documentation dated 9/9/20 at 1:44 p.m. reflected the cognition was checked as inattention and disorganized thinking. Musculoskeletal was checked as moving from seated to standing, walking, turning around and facing the opposite direction checked as not steady, only able to stabilize with staff assistance. Review of the physician/practitioner progress notes dated 9/10/20 at 11:42 a.m. reflected resident seen for a fall. She was found sitting on the floor, she verbalized, I fell . She denies hitting her head or loss of consciousness. She has a minor skin tear on her right knee. She has been observed sitting in her wheelchair at the nurses station. General: mildly lethargic, cooperative and conversive in no acute distress. She is sitting upright in bed, appears comfortable. Diagnosis/plan 7. Fall: nursing to increase rounding. [MEDICATION NAME] 5 mg twice a day discontinued per family request. Review of the skilled documentation dated 9/12/20 at 6:52 p.m. reflected Cognition was checked as inattention and disorganized thinking. Always incontinent was checked for bowel and bladder. Musculoskeletal was checked as not steady, only able to stabilize with staff assistance. Moving on and off toilet as not steady, only able to stabilize with staff assistance. Surface to surface transfer was checked as not steady, only able to stabilize with staff assistance. Review of the fall risk evaluation dated 9/9/20 at 9:07 p.m. reflected the fall risk score of 14. During the interview with the ADON on 10/13/20 at 1:36 p.m. she stated Resident #2 fell on [DATE] at 3:47 p.m. The resident was found lying on her back with a Hematoma on the backside of her head. She was found in the hallway on the south wing. The fall was not observed. Increased confusion. Unable to follow verbal commands. Resident noted with increased agitation. Called 911 and sent to hospital. Intervention on return given a high back chair she could get around in. (no one in hall way at time of fall) with change of shifts at 3:00 p.m. The ADON stated all residents are assessed by therapy on return from the hospital after a fall. The ADON stated we will do a medication review but had not come to that point with Resident #2. We were looking at other interventions for her. The ADON stated that Resident #2 came back and noted to be declining and required more assistance. Review of the SBAR form dated 8/15/20 reflected the change of condition as a fall that seems different than usual. Mental status checked as increased confusion or disorientation and functional status evaluation checked as falls. Skin evaluation checked as other and described as Hematoma to the back of head. Pain checked as new to the back of the head. Neurological evaluation checked as altered level of consciousness described as increased confusion, disorientation. Recommendations to send to the hospital for evaluation. Review of the facility document provided by the ADON dated 8/15/20 at 3:47 p.m. reflected resident noted lying on the floor on her back with wheelchair near. Hematoma to backside of head noted upon assessment. Observed with increased confusion. Unable to follow verbal commands. Noted increased tremors. No new physical functional limitation noted. Resident with noted increased agitation and attempting to get up. Blood pressure 112/66, pulse 70, respirations 20, temperature 97.1, oxygen of 95%. Ice applied to back of head while awaiting emergency transport personnel. Description to send to hospital for evaluation due to symptoms. Intervention: high back chair. Injury type: Hematoma to the back of the head. Predisposing physiological factors checked as confused and impaired memory. Predisposing situation factors checked as using wheeled walker. Review of the nursing progress notes dated 8/15/20 at 12:40 p.m. reflected resident is alert with confusion and forgetfulness, all needs met and anticipated by staff. Continues on one person assistance from staff with ADL needs. Incontinent of bowel and bladder. No acute distress noted as per attending nurse. Lacks safety awareness, fall risk. Bed in low position. Continued to be prioritized by staff for fall prevention risk due to attempt to climb out of bed. No signs and symptoms of any distress noted. Review of the nursing progress notes dated 8/15/20 at 3:47 p.m. reflected resident noted lying on the floor on her back with wheelchair near, Hematoma to back side of head noted upon assessment. Observed with increased confusion. Unable to follow verbal commands. Noted increased tremors. No new physical functional limitation noted. Resident with noted increased agitation and attempting to get up. Ice applied to back of head while awaiting emergency transport personnel. Review of the physician progress notes [REDACTED]. She was found on the floor with increased confusion and a Hematoma on her head. She was sent to the emergency room evaluated and released. She is more alert today than her previous exam. No signs or symptoms of injury. She is sitting up in a bed today and is minimally conversive but cooperative. She has no complaint of pain. she is alert to self only which is her baseline. 6. Fall: Nursing to increase rounding. Review of the fall risk evaluation dated 8/15/20 at 3:47 p.m. reflected a fall risk of 11. Review of the skilled documentation dated 8/15/20 at 12:40 p.m. reflected the cognition checked as inattention and disorganized thinking. Musculoskeletal checked as moving from seated to standing, walking, turning around and facing the opposite direction checked as not steady, only able to stabilize with staff assistance. During an interview on 10/13/20 at 1:36 p.m. with the ADON she stated that the resident fell on [DATE] at 8:30 a.m. the ADON stated the resident was observed sitting on the bathroom floor with her Foley catheter hanging from her bed that she pulled out. No injury noted. Intervention - Staff to offer toileting after breakfast. Catheter left out. Review of the facility document dated 8/8/20 at 8:30 a.m. provided by the ADON reflected the resident was observed sitting on the bathroom with her Foley catheter hanging from her bed. The resident stated she had to use the restroom. Immediate action taken: staff checked her skin from head to toe and assisted her back to her bed washed her up and assisted her into her wheel chair. Intervention: offer toileting after breakfast. Predisposing physiological factors confused, impaired memory and incontinent. Review of the nursing progress report dated 8/8/20 at 5:25 p.m. resident received alert and oriented to person only she verbalizes some of her needs but requires constant redirection earlier during day shift. Resident was observed sitting on the bathroom floor with her Foley catheter hanging from the bed. Her doctor was notified and gave orders to leave her catheter out and monitor her output she has since urinated on the toilet twice. No noted retention at this time she exhibited no apparent injuries related to the fall. no [MEDICAL CONDITION], no bruising. She has been one to one with staff, her brother was notified of fall as was the

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) ADON, resident us currently being assisted. Review of the skilled documentation dated 8/8/20 at 3:16 p.m. reflected Resident #2's cognition as altered level of consciousness. Summary reflected per attending nurse: resident is alert with confusion, all needs anticipated and met by staff. Review of the fall risk evaluation dated 8/8/20 at 8:30 a.m. reflected a fall score of 14. Review of the physician/practitioner progress notes dated 8/10/20 at 1:01 p.m. resident seen for a fall and lethargy. She was found on the floor of her bathroom with her Foley catheter discontinued. No visible trauma, patient was alert at the time. She was recently treated for [REDACTED]. She continues to be some mildly lethargic but has improved, is sitting upright in a chair today and is conversive. 6. Fall: Nursing to increase rounding. During an interview with the ADON on 10/13/20 at 1:36 p.m. the ADON stated the resident fell on [DATE] in her room and was found lying on her back between the footrest of the roommate's bed and the door of the bathroom. The resident stated she was trying to use the bathroom, a laceration noted to her left eyebrow with scant bleeding and swelling. ROM decreased on left hip with resident complaint of pain with rotation. She stated she was trying to use the bathroom and tripped on the roommates wheel chair by the bathroom. Intervention was to switch from B bed to A bed. Her eye was steri stripped. The X-ray was completed on 7/4/20 no fracture or dislocation noted. Review of the facility document dated 7/4/20 at 2:10 p.m. provided by the ADON reflected, Resident observed on her back on the floor between the footrest of room mates bed and the door of the bedroom. Resident stated that she was trying to use the bathroom. Resident was assessed for injuries and laceration noted to left eye brow with scant bleeding and mild swelling. Range of motion decreased on left hip. Resident complaint of pain on internal and external rotation of left hip. No other injuries noted. Steri strip applied to laceration on left eyebrow as well as ice pack. Intervention: steri strip applied to laceration on left eyebrow. Called placed to physician to request orders. Interventions to switch beds from B to A. Predisposing environmental factors revealed confused. other information included room mates tipper extensions on wheelchair while trying to use rest room. Review of the fall risk evaluation dated 7/4/20 at 2:10 p.m. reflected the resident with a fall score of 5. During an interview on 10/13/20 at 5:06 p.m. with Staff member A, RN she stated that Resident #2 was impulsive and lacked safety awareness. If she was put in bed she would get up. She was getting better in the beginning then she came back from the hospital at one point more confused. Staff A stated that when she was assigned to Resident #2, she would put her at the nurses station. When Resident #2 first arrived, she was able to walk and was an elopement risk. During an interview with on 10/13/20 at 5:13 p.m. with Staff member B, South West unit manager, she stated the resident was confused and alert. She came back from the hospital with wounds and was confused. She had a low air loss mattress and prior to COVID-19 she was alert and mobile. We never put her on one to one for the falls. The CNA would document on Activities of Daily Living (ADL's). During an interview with Staff member C, CNA, on 10/13/20 at 5:10 p.m. she stated, before COVID-19 the resident was not impulsive but would get up and try to walk. During an interview with Staff member D, RN, on 10/13/20 at 5:11 p.m. she stated she had the resident on the 200 unit and she would walk all the time. The resident would get confused. There was a fall and it was documented. We document in the chart and assess the resident, we start neuro checks, complete the incident report for who, what, when where and why. The nurse on shift will document on the incident report and we complete witness statements and assessments that go to the DON. During an interview with Staff member E, LPN on 10/13/20 at 5:21 p.m. he stated the resident was at risk for falls and confused. She was a fall risk and required close supervision with one to one at times and it was care planned. Review of the physical therapy discharge summary signed on 9/28/20 at 10:38 a.m. reflected summary since eval and patient response: patient was showing good progress prior to hospitalization due to fall. Pt was attempting to transfer and ambulate unassisted due to cognitive deficits. Review of Resident #2's care plan reflected a focus area related to an actual fall, initiated on 3/30/20, revised on 3/30/20. The goal was to resume actual activities without further incident through the review date with a target date of 11/11/20. Interventions initiated on 3/30/20 were to continue on the at-risk plan and dump wheelchair. Interventions initiated on 7/4/20 included switching sides of the room from the B bed to the A bed. Interventions initiated on 8/15/20 included broda chair. Interventions initiated on 9/9/20 included floor mats. Interventions initiated on 9/14/20 included up out of bed during meals. Interventions initiated on 9/26/20 included medication review. Continued review of the care plans revealed: Focus area related to impaired cognitive and communication function/dementia or impaired thought processes related to impaired decision making, [DIAGNOSES REDACTED]. Intervention to cue, reorient and supervise as needed initiated on 3/30/20. Focus area initiated on 3/27/20 to require assistance with activity of daily living (ADL) functions related to cognitive impairment. 6/25/20 resident required supervision/limited assist, 8/5/20 declined in function after hospitalization , revised on 8/5/20. Goal to safely ambulate 100 feet with four wheeled walker and supervision by next review initiated on 8/5/20, target date of 11/11/20. Goal to safely perform ADL's with supervision by next review initiated on 8/5/20, target date of 11/11/20. Interventions included ambulation -supervision with ambulation due to wandering. 8/5/20 therapy treating for increased assistance initiated on 3/30/20 and revised on 8/5/20. transfers: one assist with transfers initiated on 3/27/20, mobility: walks/wheels only with physical assistance initiated on 3/27/20. Review of the interdisciplinary [MEDICAL CONDITION] review meeting dated 9/24/20 attended by the DON, unit managers, social services, pharmacist or pharmacist recommendations review reflected the source of the information came from the patient chart, nursing staff and social services. Continue medications at current doses, staff to monitor behaviors. No side effects noted at this time. Tapering medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the residents function, well being, safety, and or quality of life. Review of the physiatrist report dated 9/18/20 reflected the resident seen via telemedicine with a plan: deconditioning- she is contact guard for bed mobility, minimum assist for transfers, ambulating 30 feet with rolling walker and moderate assistance, assist for toileting. During an interview with the Director of Nursing (DON) on 10/13/20 at 5:44 p.m., he stated the nurse starts the report for a fall. Then we discuss the fall the next morning. The interdisciplinary team (IDT) team is involved. We look at the falls and included the nurse practitioner that's here and we come up with interventions and the nurse documents for 3 days after the fall. Resident #2 was not cognitively intact and always looking for her husband who brought her in here to us. You could not get her to relax, and she was put on one to one about six months ago. After she was sick with COVID-19 she would not get out of bed and they were adjusting her medications. She used to run around the building and when she came back she would just lay in the bed. After adjusting her medications she was getting more active. We could not stop her from falling and were not aware that she had a fall with a fracture when she left us on 9/26/20. She went out for a [MEDICAL CONDITION]. Had we known she had a fracture from her fall we would have reported the fracture. The DON stated that we would typically have a fall packet that can be found on the unit. The ADON would have the documentation in a packet. At that time the ADON was asked if she had any fall packets related to the six falls sustained by Resident #2, and she stated that she does not have any packet related to falls with witness statements for this resident. The DON confirmed that he did not have any fall packets with fall investigations. The DON re-stated that the facility was not notified of the fracture but was aware of the resident going to another facility. The DON stated the facility liaison sends updates for people that went to the hospital. The DON stated that he did not have anyway of keeping Resident #2 off the floor. He said the resident was headstrong and she will just keep falling regardless of where she was located. Review of the facility's policy titled, accidents and incidents - investigating and reporting policy revised July 2017, 2 pages reflected: all accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the Administrator. 1. The nurse supervisor/charge nurse and or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. the following data as applicable shall be included on the report of incident/accident form: c. the circumstances surrounding the accident or incident; e. The name of witness and their accounts of the accident or incident; l. follow-up information. 7. Incident/accident reports will be reviewed by the Safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Review of the policy for, How to conduct an investigation revised on 5/1/11, 4 pages reflected: The facility has designed and implemented processes which strive to enable the facilities to come to resolution after thoroughly investigating all accidents, incidents, losses, thefts, etc. The person designated by the facility to be the investigator will remain objective and maintain neutrality during an investigation. Procedure: 2. The information should include who, what, when, where, how and why. 8. Document a brief, concise, objective description, in the medical record of what was actually observed. 10. Determine what' occurred, what is the chronological order of action leading up to the alleged incident, what information does other relevant staff members, roommate, family members have of the incident or factor leading up to the incident. 16. Conclude how the incident occurred. 17. Conclude if/how the incident could have been avoided.