

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2011
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NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210
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F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>An abbreviated survey (KY# 15860) was conducted 06/22-24/11. The allegation was substantiated and deficiencies were cited, with the highest scope and severity at a "D".</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure the comprehensive care plan was reviewed and revised after post fall investigations, for one resident (#1), in the selected sample of six residents. Resident #1</p>	F 280	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F 280</p> <p>Resident #1's comprehensive care plan was reviewed and revised to reflect current status of resident, to include identified preventive interventions, on June 24, 2011 by the licensed nursing staff.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carolyn Yonence</i>	TITLE <i>Administrator</i>	(X6) DATE <i>07202011</i>
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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 280	Continued From page 1 sustained three falls from the wheelchair, which occurred, on 11/13/10, on 01/14/11 and on 05/14/11. The resident sustained bruises and a hematoma as a result of two of the three falls. The facility failed to ensure the resident's care plan was reviewed and revised to include preventive interventions, based on a thorough investigation after each fall. The findings include: A review of the facility's policy and procedures entitled, "Fall Management Program" dated January 2008 and revised December 2010, revealed the fall management program was an interdisciplinary program that utilized the "APIE" (assess, plan, implement, and evaluate) approach to provide care related to falls. The program's components included identification of residents at risk for falls, implementation of interventions to prevent falls, ensure a focus on a safe environment and reduce the likelihood of injury from a fall, and manage falls. A record review revealed Resident #1 was admitted to the facility, on 10/01/06, with diagnoses to include left side Hemiplegia, Osteoporosis, Osteoarthritis and Abnormal Posture. A review of the comprehensive care plan, dated 03/02/07, revealed the facility identified Resident #1 as at risk for falls related to a history of falls, unsteady gait and standing balance, impaired safety awareness and not calling for assistance with transfers, and included interventions for the use of a pressure reducing wedge cushion to the wheelchair and Deloid (a non slip material). Additional interventions included ensuring commonly used articles/personal items were kept	F 280	Comprehensive care plans for current residents that are at risk for falls will be reviewed by IDT staff which includes the Director of Nursing, Assistant Director of Nursing, MDS Coordinator and MDS Assistant, by July 20, 2011 to ensure all preventive interventions are included. Licensed nursing staff have been re-educated on the Fall Management Program using the APIE approach, identifying root cause of falls, updating residents comprehensive care plans and implementing preventive interventions by the Director of Nursing Services, Assistant Director of Nursing Services and Staff Development Coordinator on July 7, 2011. A member of the IDT staff will conduct weekly audits of comprehensive care plans for one month and monthly audits for two months for current residents at risk for falls to ensure all preventive interventions have been identified and are included in those comprehensive care plans. Results of these audits will be brought monthly by the Director of		

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F 280	Continued From page 2 within easy reach, the resident wore proper non-slip footwear, the call light remained within easy reach of the resident and the resident was to communicate needs and ask for assistance. A review of the Nursing Assistant Care plan, dated 03/02/07, revealed an intervention to, "Always remove foot rest during all transfers". 1. A review of a "Change of Condition Documentation", dated 11/13/10 at 7:00 PM, revealed Certified Nurse Aid (CNA) #1, pushed Resident #1 in a wheelchair to the resident's room. During the process, Resident #1 leaned forward in the wheelchair and fell out of the wheelchair. The resident sustained a golf ball sized hematoma to the forehead above the left eye, as a result of the fall. The facility transferred the resident to the local hospital for evaluation and treatment. A review of the facility's investigation, revealed the root cause of the fall was identified as, "The resident leaning forward in the wheelchair and fell to the floor." The investigation revealed the Clinical Management Team determined the fall was related to the resident's "cognition" and a referral was made for the resident to be screened by Occupational Therapy (OT) related to wheelchair positioning. There were no new care plan revisions made, until 11/17/10, when interventions were to reinforce the resident's need to call for assistance, Physical Therapy (PT) /Occupational Therapy(OT)/ Speech Therapy (ST) to screen as indicated, ensure the environment was free of clutter and encourage the resident to transfer and change positions slowly was added.	F 280	Nursing to the Performance Improvement Committee for further review and recommendations. Completion date	07/21/2011	

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F 280	<p>Continued From page 3</p> <p>An interview with the Therapy Manager/Registered Occupational Therapist, on 06/23/11 at 10:24 AM, revealed all residents were screened by therapy after a fall. She stated she was "pretty sure" Resident #1 was picked up by therapy and added to the OT caseload, on 11/18/10, five days after the fall, for positioning and staff education for proper wheelchair positioning. Resident #1 was placed in a lighter weight lower wheelchair. The resident also received therapy, related to wheelchair propulsion with adaptive equipment.</p> <p>2. A review of a "Change of Condition Documentation", dated 01/14/11, at 4:15 PM, revealed Resident #1 fell from the wheelchair a second time, while in his/her room and was found on the floor at the foot of the bed by staff. There was a pool of blood near the resident's head, the result of a laceration to the left side of the forehead. Resident #1 was transported to the local hospital for evaluation and treatment. The fall was unwitnessed.</p> <p>Review of the facility's investigation revealed the root cause of the fall was identified as the wheelchair. The resident reported the wheelchair dumped her and stated, "I was falling out of my chair and called out for help." The Clinical Management Team determined the fall was related to environmental factors and recommended Dycem and anti-tippers to the wheelchair. However, Dycem was not a new intervention and had been a part of the care plan, since 03/02/07.</p> <p>3. Review of the "Change of Condition Documentation", dated 05/14/11 at 8:15 PM,</p>	F 280			

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F 280	Continued From page 4 revealed Resident #1 fell the thrd time from the wheelchair. CNA #2 was in the process of pushing Resident #1 in the wheelchair to his/her room and the resident's left foot fell off the foot rest, causing the resident to be thrown to the floor. Resident #1 sustained bruising to the left knee as a result of the fall. A review of the facility's investigation, revealed the root cause of the fall was identified as " hemiplegia non-dominant (left) side related to cerebrovascular disease, foot fell off wheelchair footrest while resident was being propelled in wheelchair." A referral for Resident #1 to be evaluated by therapy related to positioning of the lower extremities when in the wheelchair was made. The Clinical Management Team determined the fall was identified as an Orthopedic issue and a recommendation for therapy to evaluate positioning of the lower extremities in the wheelchair was made. Review of the care plan revealed an intervention to have therapy evaluate the resident for postioning of the lower extremity while in the wheelchair. However, record review revealed the evaluation was not provyded, until 05/25/11, 11 days after the fall. An interview with Licensed Practical Nurse #1, on 06/23/11, revealed she was the nurse assigned the resident's unit, on 05/14/11. She stated she did not wltness the resident's fall; however, she conducted an investigation, which revealed the resident's foot rolled off the foot pedal and went underneath the wheelchair, causing the resident to be thrown forward out of the wheelchair. She made a referral for therapy to evaluate the resident for postioning, due to the fact the resident was flaccid on the left side and had	F 280			

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F 280	Continued From page 5 ongoing problems with leaning forward and to the side.	F 280			
	<p>An interview with the Therapy Manager, on 06/23/11 at 10:24 AM, revealed Resident #1 was not "picked up" by therapy for 11 days after the fall, on 05/25/11, due to "staff needs". She stated the resident was not evaluated for positioning of the lower extremity.</p> <p>Review of the physician orders, dated 06/03/11, revealed the resident was to wear a foam torso support, when up in the wheelchair to increase positioning and ease with wheelchair propulsion as needed. Review of the care plan revealed these interventions were not included.</p> <p>A review of Treatment Administration Record, dated 06/01-30/11, revealed orders for the resident to wear the foam torso support as needed, while up in wheelchair, to increase positioning and ease with wheelchair propulsion.</p> <p>An observation, on 06/22/11 at 9:55 AM, revealed Resident #1 was seated in a wheelchair at the foot of his/her bed. The resident's head and torso were leaned forward and the resident's eyes were closed. Observation revealed the foam torso support was not in place.</p> <p>An interview with Resident #1, on 06/23/11 at 2:00 PM, revealed he/she believed the fall, which occurred, on 01/14/11, was caused by the resident reaching down for the heater; however, the other two falls, "happened because they were going too fast." The resident stated on both occasions, he/she attempted to tell staff he/she was falling. Resident #1 stated the falls</p>				

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F 280	Continued From page 6 happened so fast, he/she didn't know whether his/her left foot remained on the foot rest. Resident #1 stated he/she reported the situation to staff, but felt the staff didn't believe him/her. She could not identify the staff who provided the information. An interview with the Assistant Director of Nursing (ADON), on 06/23/11 at 4:00 PM, revealed nursing staff were responsible for interventions and updating the care plan, after falls and providing follow up by way of the Treatment Administration Record and Nurses Notes. Post fall assessments were conducted after a fall and on a quarterly basis. The ADON stated she felt the interventions after falls experienced by Resident #1 were appropriate. (Refer to F323)	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure the resident environment was as free from accident hazards as possible and adequate supervision to prevent accidents was provided for one resident (#1), in the	F 323	F 323 Resident #1's wheelchair had left leg calf and foot support added to prevent her foot from sliding off the wheelchair pedal by Occupational Therapy Assistant on July 13, 2011. The Assistant Director of Nursing Services re-educated staff on June 24, 2011 to assess placement of resident #1's feet while providing care. Current residents that have been identified at risk for falls will have an audit completed by a member of the IDT to ensure resident's physician		

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F 323	Continued From page 7 selected sample of six residents. Resident #1 sustained three falls from the wheelchair, which occurred, on 11/13/10, on 01/14/11 and on 05/14/11. The resident sustained bruises and a hematoma as a result of two of the three falls. The findings include: A review of the facility's policy and procedures entitled, "Fall Management Program" dated January 2008 and revised December 2010, revealed the fall management program was an interdisciplinary program that utilized the "APIE" (assess, plan, implement, and evaluate) approach to provide care related to falls. The program's components included identification of residents at risk for falls, implementation of interventions to prevent falls, ensure a focus on a safe environment and reduce the likelihood of injury from a fall, and manage falls. A record review revealed Resident #1 was admitted to the facility, on 10/01/06, with diagnoses to include left side Hemiplegia, Osteoporosis, Osteoarthritis and Abnormal Posture. A review of the annual Minimum Data Set (MDS) assessment, dated 10/17/10, revealed the facility identified Resident #1 as cognitively intact, non-ambulatory and required extensive assistance of one to two staff for bed mobility, transfers and bathing. A review of the comprehensive care plan, dated 03/02/07, revealed Resident #1 was at risk for fall related to a history of falls, impaired safety awareness and not calling for assistance with transfer and unsteady gait and standing balance.	F 323	orders, comprehensive care plan, C.N.A. care card and preventative interventions match. This audit will include identification of environmental hazards and any identified issues will be corrected. This audit will be completed by July 19, 2011. Licensed nursing staff have been re-educated on the Fall Management Program using the APIE approach, identifying root cause and implementing preventive interventions by Director of Nursing Services, Assistant Director of Nursing Services and Staff Development Coordinator on July 7, 2011. A member of the IDT will conduct weekly audits for one month and monthly audits for two months on residents at risk for falls to ensure all preventive interventions have been identified and are in place. Results of these audits will be brought monthly by the Director of Nursing to the Performance Improvement Committee for further review and recommendations. Completion date	07/21/2011	

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F 323	Continued From page 8 Interventions included the use of Dycem (a non slip material). Interventions also included ensuring commonly used articles/personal items were kept within easy reach, the resident wore proper non-slip footwear, the call light remained within easy reach of the resident and the resident was to communicate needs and ask for assistance. The Nursing Assistant Care plan, dated 03/02/07, revealed an Intervention to, "Always remove foot rest during all transfers".	F 323	
	<p>1. A "Change of Condition Documentation", dated 11/13/10 at 7:00 PM, revealed Certified Nurse Aid (CNA) #1, pushed Resident #1 in a wheelchair to the resident's room. Resident #1 leaned forward in the wheelchair and fell out of the wheelchair. Resident #1 sustained a golf ball sized hematoma to the forehead above the left eye, as a result of the fall. The resident was transferred to the local hospital for evaluation and treatment.</p> <p>The facility's investigation, revealed the root cause of the fall was identified as the resident leaned forward in the wheelchair and fell to the floor. The investigation revealed the Clinical Management Team determined the fall was related to the resident's "cognition" and a referral for wheelchair positioning, was made for the resident to be screened by Occupational Therapy. An intervention to apply Dycem, a non-slip material, was included as a measure to be taken based on the investigation. However, Dycem had been implemented on 03/02/07 and was still in place at the time of the fall. There were no new care plan revisions made until four days after the fall, on 11/17/10, when interventions were added to reinforce the</p>		

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F 323	Continued From page 9 resident's need to call for assistance, Physical Therapy/Occupational Therapy/Speech Therapy to screen as indicated, ensure the environment was free of clutter and encourage the resident to transfer and change positions slowly. During an interview with CNA #1, on 06/23/11 at 10:14 AM, she revealed Resident #1 sustained a fall from the wheelchair, on 11/13/10. She was pushing Resident #1 in his/her wheelchair from the bathroom, when the resident leaned forward and fell from the wheelchair. CNA #1 thought the resident's foot might have dragged on the floor and caused her to fall, since this had occurred before. CNA #1 stated the left leg/foot rest was in place, at the time of the fall. An interview with the Therapy Manager/Registered Occupational Therapist, on 06/23/11 at 10:24 AM, revealed all residents were screened by therapy after a fall. She stated she was "pretty sure" Resident #1 was added to the Occupational therapy (OT) caseload, on 11/18/10, (five days after the fall), for positioning and staff education for proper wheelchair positioning. A lighter weight, lower wheelchair was implemented and the resident also received therapy for wheelchair propulsion with adaptive equipment. 2. A "Change of Condition Documentation", dated 01/14/11, at 4:15 PM, revealed Resident #1 fell from the wheelchair a second time, while in his/her room and was found by staff, on the floor at the foot of the bed. There was a pool of blood near the resident's head. The unwitnessed fall resulted in a laceration to the left side of the resident's forehead. Resident #1 was transported	F 323			

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F 323	Continued From page 10 to the local hospital for evaluation and treatment.	F 323		
	<p>Review of the facility's investigation revealed the facility identified the root cause as the fall from the wheelchair. The resident reported the wheelchair dumped her and stated, "I was falling out of my chair and called out for help." Further review of the facility's investigation revealed the intervention implemented after the fall was Dycem to be applied to the wheelchair. The Clinical Management Team's determined the fall was related to environmental factors and recommended Dycem and anti-tippers to the wheelchair. However, according to the resident's care plan, Dycem was not a new intervention and had been used since 03/02/07.</p> <p>An interview with the Therapy Manager, on 06/23/11 at 10:24 AM, revealed Resident #1 was not seen by OT until four days after the fall, on 01/18/11. OT recommendations included a left lateral support and a regular low wheelchair. The lateral support was added to prevent the resident's left arm from being caught in the wheel of the wheelchair. Additionally, front anti-tippers were added to the wheelchair, to prevent the resident from falling forward from the wheelchair.</p> <p>3. A "Change of Condition Documentation", dated 05/14/11 at 8:15 PM, revealed Resident #1 fell the third time from the wheelchair. CNA #2 was pushing Resident #1 in the wheelchair to his/her room and the resident's left foot fell off the foot rest, causing the resident to be thrown to the floor. Resident #1 sustained bruising to the left knee as a result of the fall.</p> <p>An interview with CNA #2, on 06/23/11 at 12:38</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2011
NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 11</p> <p>PM, revealed she was pushing Resident #1 in his/her wheelchair from the whirlpool room after a shower, on 05/14/11. Resident #1's left foot fell off the foot pedal, the resident's foot and leg then got caught under the wheelchair, which caused the resident to fall from the wheelchair. She stated it was not unusual for Resident #1 to lean forward while in the wheelchair. Also, the wheelchair had one foot rest, which was removed for transfers.</p> <p>An interview with CNA #3, on 06/23/11 at 12:48 PM, revealed she was walking behind CNA #2 as CNA #2 pushed Resident #1 in the wheelchair from the whirlpool to the resident's room. She stated CNA #2 forgot to place the leg/foot rest back on the wheelchair before leaving the whirlpool room. She saw Resident #1's foot get caught under the wheelchair and witnessed the resident fall forward onto the floor and land on his/her knees.</p> <p>An interview with the Certified Medication Technician (CMT), on 06/24/11 at 9:30 AM, revealed she was walking down the hall, facing the resident on 05/14/11, when she observed Resident #1's foot go under the wheelchair, which caused the resident to fall out of the wheelchair onto his/her knees. The CMT stated she could not recall the leg/foot rest being in place on the wheelchair.</p> <p>An interview with Licensed Practical Nurse #1, on 06/23/11, revealed she was the nurse assigned the resident's unit, on 05/14/11. She stated she did not witness the resident's fall; however, she conducted an investigation, which revealed the resident's foot rolled off the foot pedal and went</p>	F 323		

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F 323	Continued From page 12 underneath the wheelchair, causing the resident to be thrown forward out of the wheelchair. She stated the resident was flaccid on the left side and had ongoing problems with leaning forward and to the side, so she made a therapy referral to evaluate for positioning. A review of the facility's investigation, revealed the root cause of the fall was identified as " hemiplegia non-dominant (left) side related to cerebrovascular disease, foot fell off wheelchair footrest while resident was being propelled in wheelchair." A referral for Resident #1 to be evaluated by therapy related to positioning of the lower extremities when in wheelchair was made. The Clinical Management Team determined the fall was identified as an Orthopedic issue and a recommendation for therapy to evaluate positioning of the lower extremities in the wheelchair was made. Review of the care plan revealed the intervention to have therapy evaluate the resident for positioning of the lower extremity while in the wheelchair. However, record review revealed the evaluation was not provided, until 05/25/11, 11 days after the fall. An Interview with the Therapy Manager, on 06/23/11 at 10:24 AM, revealed Resident #1 was not "picked up" by therapy for 11 days after the fall, on 05/25/11, due to "staff needs". She stated the resident was not evaluated for positioning of the lower extremity. Review of physician orders, dated 06/03/11, revealed the resident was to wear a foam torso support, when up in the wheelchair to increase positioning and ease with wheelchair propulsion as needed. Review of the care plan revealed	F 323			

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F 323	Continued From page 13 these interventions were not included.	F 323			
	<p>A review of Treatment Administration Record, dated 06/01-30/11, revealed orders for the resident to wear the foam torso support as needed, while up in the wheelchair, to increase positioning and ease with wheelchair propulsion.</p> <p>An observation, on 06/22/11 at 9:55 AM, revealed Resident #1 was seated in a wheelchair at the foot of his/her bed. The resident's head and torso were leaned forward and the resident's eyes were closed. Observation revealed the foam torso support was not in place.</p> <p>An interview with Resident #1, on 06/23/11 at 2:00 PM, revealed he/she believed the fall, which occurred, on 01/14/11, was caused when he/she reached down for the heater; however, the other two falls, "happened because they were going too fast." The resident stated on both occasions, he/she attempted to tell staff he/she was falling. Resident #1 stated the falls happened so fast, he/she didn't know whether his/her left foot remained on the foot rest. Resident #1 stated he/she reported the situation to staff, but felt the staff didn't believe him/her. The resident could not identify the staff provided the information.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 06/23/11 at 4:00 PM, revealed the individual staff member, responsible for submission of the "Hey Therapy" referral was responsible for the follow-up with therapy. Nursing staff were responsible for interventions and updating the care plan, after falls and providing follow up by way of the Treatment Administration Record and Nurses Notes. Post</p>				

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F 323	<p>Continued From page 14</p> <p>fall assessments were conducted after a fall and on a quarterly basis. The ADON stated she felt the interventions after falls experienced by Resident #1 were appropriate.</p> <p>An interview with the Administrator, on 06/24/11 at 3:10 PM, revealed the Quality Assurance/Safety team met on a monthly basis and the Falls Tracking/Trending form was reviewed, during the meeting.</p>	F 323		
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