STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING _____ B. WING _____	C 04/28/2011

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MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH RD PO BOX 2344 BRYSON CITY, NC 28713

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F 323 SS=J	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 medical record review, observations and interviews with staff the facility failed to supervise one of one residents during transport in the facility van. Van Driver #5 left Resident #1 unattended in the facility van with the engine running while Van Driver #5 went into the facility. The vehicle rolled down an embankment, across a road and into a wooded area stopping against a tree. Immediate jeopardy began on 4/17/11 at 2:00 PM when Resident #1 was left unsupervised inside the van with the engine running. Immediate jeopardy was removed on 4/28/11 at 6:45 PM. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings are: Review of the facility transportation policy dated 9/15/2008 revealed: "It is the policy of Mountain	F 323	**This Plan of Correction is being submitted pursuant to the applicable Federal and State regulation. Nothing contained herein shall be construed as an admission that the facility violated any Federal or State regulation or failed to follow any applicable standard of care.** **Please allow our Plan of Correction to constitute our Allegation of Compliance. All issues are addressed; all issues have been corrected and will be in place when the van returns to service (date unknown).** Resident #1 was assessed by the RN Supervisor and monitored by staff until Emergency Management Services arrived. EMS transported resident #1 to the hospital for evaluation. Later the same day the resident returned with no new orders and no apparent injuries. Resident #1 will receive continual supervision with all transports by the van driver. On April 28, 2011 the Administrator conducted an audit of all other interviewable residents transported via the facility van since January 01, 2011. The audit included interviews with residents to determine if any other resident was affected by the deficient practice. The findings from this audit revealed that no other resident was affected by the deficient practice. Facility residents will receive continual supervision by the van driver during transports. continued	04/28/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
✓ Donna Reade Ramsey NHA ✓	NHA	✓ 5-18-2011

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 323	Continued From page 1 View Manor Nursing Center to transfer residents to their medical appointments utilizing the facility's van. The Van Driver will transport and assist the resident to his/her appointment and will remain with the resident until appointment is completed, then will return to the Facility via the Facility Van." Resident #1 was admitted to the facility on 9/4/09 with diagnoses which included: vascular dementia, anemia, general muscle weakness, chronic kidney disease-stage 4, hypertension, coronary artery disease, congestive heart failure and chronic pain syndrome. A review of the most recent Minimum Data Set (MDS), a quarterly assessment dated 2/18/11, revealed the resident had severe memory and cognitive impairment. It further revealed the resident was ambulatory with the limited assistance of one staff member and was independent with transfers with set-up help or supervision. A review of Resident #1's medical record revealed a nurse's note dated 4/17/11 at 12:45 p.m. which indicated Resident #1 was to be transported to the hospital emergency department in the facility van for complaints of a headache. A later nurse's note dated 4/17/11 at 2:00 P.M. read: "Resident involved in motor vehicle incident while in process of being taken to Emergency Room via facility van. EMS (Emergency Medical Services) called and transported resident to hospital". A review of Resident #1's hospital medical record revealed that she arrived at the Hospital Emergency Department on 4/17/11 at 2:29 P.M. A physician's progress note dated 4/17/11 at 2:34 P.M. revealed: "She denies any complaints	F 323	The van was immediately taken out of service and sent to a local garage for inspection and has not been driven since April 17, 2011 On April 27, 2011 and April 28, 2011 all van drivers were inserviced by the Safety Director, the Administrator, and the Director of Nursing on the importance of not leaving a resident unattended in the van. They are to use a cell phone after bringing the van to a complete stop in a safe area. Also, van drivers were instructed that prior to exiting the van the driver will place the van in park, engage the emergency brake, and turn the van off. Wheel chocks are to be used under the front and back of a tire the as soon as the van driver exits the vehicle. On April 27, 2011 the Van Transfer Policy was updated to reflect that the resident is not to be left unattended in the van; if the van driver requires assistance they are to stop in a safe area and use a cell phone to call the facility or to call 911. Wheel chocks are to be used under the front and back of a tire as soon as the van driver exits the vehicle. Three permanent signs will be posted in the van that state **"Never leave resident unattended"** in large bold letters. These signs will be posted on the dash, on the right inside of the rear door, and on the back of the lift. continued	

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F 323	Continued From page 2 currently but she had a headache earlier. Head CT (Computerized Tomography) shows no abnormalities." A review of the findings from the physical examination did not reveal any injuries sustained in the motor vehicle accident. Resident # 1 was released from the Emergency Department on 04/17/11 at 5:28 P.M. and transported back to the facility. Review of the facility's written investigation of the incident dated 4/19/11, included the following: the police investigation report, the facility incident/accident report, a statement by Van Driver #5 who was transporting Resident #1 on 4/17/11 and a statement by Van Driver #2 who assisted Van Driver #5 with positioning Resident #1 in the facility van prior to transport on 4/17/11. Review of the facility Incident/Accident report related to the accident on 4/17/11 revealed: "Resident loaded into van to go to emergency room. Van had malfunction and rolled over bank. 911 called and first aid given. Resident complained of arm, neck and chest pain. Aide applied C-spine hold until EMS arrived. No visible injuries to resident. Resident alert and oriented and talking to staff. Refused C-spine collar when EMS arrived. Resident taken to emergency room. Resident was securely strapped in van". The undated statement by Van Driver #5 read, "Driver got in van, driver's seat, reached to put seat belt on and pressed the brake pedal, pedal went all the way to the floor. Driver had not taken van out of gear prior to attempting to press the brake. Driver got out of van and came to tell (name of Van Driver #2)". The statement by Van Driver #2 dated 4/17/11	F 323	New van drivers will have orientation on the safe operation of the van by the senior driver and skills will be checked off. The skills checklist has been updated to reflect that new van drivers will drive the van to a minimum of five appointments under the supervision of an experienced van driver. The skills check list now includes to never leave a resident unattended, to use a cell phone to call for assistance, and to use wheel chocks immediately upon exiting the van. All current drivers were retested on the skills checklist on April 28, 2011 by the Safety Director. All current drivers passed the test. On April 27, 2011 all van drivers were inserviced by the Safety Director, the Administrator, and the Director of Nursing on the importance of never leaving a resident unattended in the van. They are to use a cell phone after bringing the van to a complete stop in a safe area. Also, van drivers were instructed that prior to exiting the van the driver will place the van in park, engage the emergency brake, and turn the van off. Wheel chocks are to be used under the front and back of a tire as soon as the van driver exits the vehicle. Three permanent signs will be posted in the van that state "**Never leave resident unattended**" in large bold letters. These signs will be posted on the dash, on the right inside of the rear door, and on the back of the lift. continued	

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F 323	Continued From page 3 read, "Around 2:00 PM (name of Van Driver #5) came and got me to help him load a resident in the van to take her to the emergency room. (name of Van Driver #5) and I loaded and secured resident in van. All tie downs were tight and seat belt in place. Van was in park and the emergency brake was applied. After securing resident I returned inside the building. About one minute later (name of Van Driver #5) returned to get me and stated 'there's something wrong with the brakes'. I was returning to the van with (name of Van Driver #5) and when we got to the door I noticed the van was rolling. (Name of Van Driver #5) and I started running toward the van in an attempt to stop the van. 911 called immediately." Review of the police investigation dated 4/17/11 at 2:59 PM included: Upon my arrival, I noticed a vehicle sitting in the woods. The vehicle had front end and rear end damage. The driver side door was open. They (staff) advised no one was hurt but that a female was being transported to the (name of hospital) due to other problems. The staff stated that the van rolled off the hill. I asked who had been driving it, they advised (name of Van Driver #5). I asked him (Van Driver #5) what happened, he stated that they had loaded up (name of Resident #1) to take her to the E.R. and when he got in to drive, he noticed that the brakes were soft. He (Van Driver #5) stated, "I do the same thing every time I get into a car to drive. I put on my seat belt and as I'm doing that I always mash the brake pedal and pull it into gear. But I noticed that the brake pedal was soft so I took off my seat belt and walked inside to let them know that the brakes were soft and as I walked back out the door I saw the van rolling off the hill." (Name of Van Driver #5) stated that he	F 323	Wheel chocks will be placed under the front and back of a tire any time the van is parked to load or unload a resident. Monthly Q/A of the van preventative maintenance safety checklist will be review by the senior van driver, the Safety Director, and Administrator for compliance. The Director of Nursing or the Safety Director will do a weekly ride-along audit of van/personal vehicle safety, that a resident is never unattended, the experience of the driver, the signs are in the van, and chocks are used under the front and back of a tire when loading or unloading residents. During these audits the van drivers will also be observed to ensure that they place the van into park, set the emergency brake, and turn the van off prior to exiting the vehicle. The Administrator will monitor the audit for compliance and provide a monthly report to the QA committee for review and appropriate follow-up action if indicated. On April 27, 2011 the Van Transfer Policy was updated to reflect that the resident is never to be left unattended in the van; if the van driver requires assistance they are to stop in a safe area and use a cell phone to call the facility or to call 911. Wheel chocks are to be used under a front and back tire immediately when the van driver exits the vehicle. continued	

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F 323	Continued From page 4 left the van in park with the parking brake set. The only person that was reported being in the van was (name of Resident #1) and she remained secured in the back of the van. I called for a wrecker. Upon their arrival, I explained to them what I had been told what had happened. I asked if they would test the brakes and transmission out when they got the van back into the road. When they started to move the van I noticed that the back tires were just sliding in the leaves. They had to stop and put the van out of gear and take off the parking brake to get the van to roll. When the van was sitting in the road the wrecker driver tested out the parking brake. The van would not move with the brake set. The wrecker driver even put the van into drive and gave it gas and the van did not move. At that point he put the van in park and let off the parking brake. The van held itself with the vehicle being in just park. The area where the van was tested was steeper than the area the van rolled off of. The wrecker driver stated there was no problem with the brakes or transmission. The drive shift was OK. If the van was in park and parking brake was used the van should not have rolled off. It appears that the van had been left in neutral or drive and brake left off. No reported injuries. Interview on 4/26/11 at 9:30 AM with the Administrator revealed Van Driver #5 had been hired 4/11/11 with job duties to include van transport. The Administrator stated the van was taken to the mechanic's garage after the incident on 4/17/11 and remained there. The Administrator stated that since the incident on 4/17/11 the mechanic had verbally told him the vehicle was tested and no mechanical problems were found. The Administrator stated that in the	F 323	In interim until the van is back in service residents with outside facility appointments will be transported to appointment by: 1. If resident is ambulatory, transport will be by a designated van driver in their personal vehicle. The ambulatory resident's family members can transport if they are willing to transport in their personal vehicle. 2. If resident is non-ambulatory, transport will be by non-emergency transport (Swain County EMS). For the associate that transports with their personal vehicle, a vehicle safety check and a skill sheet for that driver will be reviewed by the Safety Director before they are allowed to transport residents in their personal vehicle. The same policy as the van policy will be followed. continued	

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F 323	Continued From page 5 interim a staff member's personal vehicle was being used to transport ambulatory residents. The Administrator stated no re-training of van drivers had been done and he had not yet met with the drivers to discuss the incident. The Administrator provided service records from the garage where the facility van was serviced which indicated the last time the van was in for service was 3/8/11 for an oil change. On 4/26/11 at 10:30 AM the facility Director of Nursing (DON) stated there were six van drivers but most resident transports were done by Van Driver #1, the primary driver. On 4/26/11 at 10:45 AM the Administrator provided a copy of the Daily Van Safety Checklist and indicated the identified items on the sheet were checked every time the van was driven. The items indicated on the sheet included: directional signs, head lights, brake lights, windshield wipers, horn, backup alarm, tires and stop lights. These sheets indicated a safety check had been done on the facility van 4/11/11-4/17/11. Staff were unable to identify who completed the safety check on 4/17/11. An interview was conducted with the facility Administrator on 04/26/11 from 12:10 P.M. through 12:25 P.M. and the accident scene was observed. The Administrator was unaware of the exact position of the parked van on 4/17/11 when Resident #1 was left unsupervised by Van Driver #5. The Administrator stated Van Driver #5 could provide that information. The Administrator demonstrated the direction the van rolled on the day of the accident. The van rolled approximately 57 feet from the front walkway before rolling up	F 323	The one personal vehicle that has the possibility of transporting residents was inspected by the facility's Safety Director to verify the safety of the personal vehicle used for resident transport. This inspection included reviewing and obtaining a copy of the registration card, the vehicle inspection statement, and all maintenance records for the personal vehicle used for resident transport. Copies of these records will be kept on file in the Safety Director's office. The Safety Director checked the vehicle with the Personal Vehicle Safety Checklist (copy attached) that includes directional signals, functioning seat belts, functionality of the brake pedal, headlights, brake lights, windshield wipers, horn, tires, and emergency flashers on the personal vehicle used for resident transport. Skills check list has been updated to reflect that new van drivers will drive the van to a minimum of five appointments under the supervision of an experienced van driver. The skills check list now includes to not leave a resident unattended, to use a cell phone to call for assistance, and to use wheel chocks immediately upon exiting the van. Three permanent signs will be posted in the van that state **"Never leave resident unattended"** in large bold letters. These signs will be posted on the dash, on the right inside of the rear door, and on the back of the lift. continued	

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F 323	Continued From page 6 and over an 8 inch curb. It then rolled over an azalea bush and partially knocked it down as well as two sections of wooden fence before rolling down another 8 inch curb. It then rolled approximately 25 feet across the facility drive and up another 8 inch curb. The van then rolled another 72 feet down a steep embankment with an approximate 70 degree slope. At the bottom of the embankment was a shallow drainage ditch at the edge of a two-lane highway. The van travelled across a two-lane highway and approximately 43 feet into a wooded area before coming to rest against a tree. The posted speed limit for the highway was 35 miles per hour and there was a sharp curve on each side of the section of highway the van crossed. The Administrator described the highway as a "busy road". On 4/26/11 at 11:45 AM the DON stated Van Driver #5 had been trained on 4/11/11 by Van Driver #1 and on 4/13/11 by Van Driver #2. On 4/26/11 at 1:00 PM and 4/27/11 at 11:40 AM Van Driver #1 stated he was the primary driver of the facility van. Van Driver #1 stated that Van Driver #5 was the first driver he ever trained. Van Driver #1 stated he had Van Driver #5 travel with him on 4/13/11 during a van transport as part of the training. Van Driver #1 stated he reviewed all items on the Skilled Sheet For The Van Driver which included the following skills: How to Sign Resident Out of Facility, Obtaining Paperwork From Charge Nurse, Letting Lift Down on the Van for Resident entrance/dismount, How to get Resident into and out of van safely, Locking wheelchair/geri-chair down, Putting seat belt around resident, Hooking tie downs/safety belts to chair, Write starting mileage-resident	F 323	All van drivers will be inserviced every 6 months by the Safety Director, the Administrator, and the Director of Nursing on the importance of never leaving a resident unattended in the van. They are to use a cell phone after bringing the van to a complete stop in a safe area. Wheel chocks are to be used under the front and back of a tire as soon as the van driver exits the vehicle. The Director of Nursing or Safety Director will do random weekly checks of van safety for 3 months or until substantial compliance is achieved then monthly. Any areas of concern will be addressed immediately and reported to the QA Committee. The Director of Nursing or Safety Director will do random weekly ride-along checks on residents in the van for 3 months, then monthly for 3 months or longer until discontinuation approved by the QA Committee. Any areas of concern will be addressed immediately and reported to the QA Committee for review. The Director of Nursing or Safety Director will check new van drivers' orientation before releasing a driver to transport residents without an experienced van driver. The Administrator will monitor the random checks for compliance and provide a monthly report to the QA committee for review and appropriate follow-up action if indicated. **All issues are addressed as of April 28, 2011; corrective actions will be in place when the van is repaired or replaced (date unknown).** continued	

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F 323	Continued From page 7 name-destination, Getting resident out of van at destination, Getting resident into appointment building, Checking resident in at the check-in desk, Returning resident to Facility, Giving paperwork to Charge Nurse and Write ending mileage. The Skilled Sheet For The Van Driver for Van Driver #5 was signed and initialed on 4/13/11 to indicate all skills had been reviewed. Van Driver #1 stated he knew a van driver should be observed driving the facility van prior to transporting a resident independently although it wasn't included as a skill on the Skilled Sheet for the Van Driver. Van Driver #1 stated that events of the day on 4/13/11 prevented him from observing Van Driver #5 driving the facility van before he was allowed to drive it alone. Van Driver #1 stated that he did not know if there was a policy on leaving residents unsupervised in the van and he did not review anything regarding this when training Van Driver #5. Van Driver #1 stated there had been times when he had to leave a resident in the van after securing them to pick up paperwork in the facility. Van Driver #1 stated that since the accident he had not met with the administrator to discuss any changes that would be put into place. On 4/26/11 at 1:55 PM Van Driver #2 stated she had trained Van Driver #5 on 4/11/11 during a transport of a resident. Van Driver #2 stated during the training she was driving the van but went over all the details of transporting a resident including how to secure a resident in the van, the daily safety checklist, how to operate the lift and to use the emergency brake whenever the van was not in motion.	F 323	**ADDENDUM to PoC** **Additional changes and safeguards:** **1. Driveway and road guardrails have been added to Mountain View Manor Nursing Center property.** **2. Additional van parking / loading space has been provided in the rear of the building.** **3. Prior to the van being utilized on the road all drivers will be inserviced again and safety van checks will be performed.**	5/21/11 PER CONVERSATION WITH ADMINISTRATOR ON 5/14/11 DM.

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F 323	Continued From page 8 Van Driver #2 stated she was working on 4/17/11 when Van Driver #5 was called in to transport Resident #1 to the hospital. Van Driver #2 stated she knew it was his first time driving the van so she offered to assist with securing the resident in the van. Van Driver #2 stated the van had been brought to the front entrance of the facility and was facing the driveway entrance. Van Driver #2 stated the van was in park and the engine was running while she was assisting Van Driver #5 with getting the resident secured in the van. After securing the resident in the van, Van Driver #2 stated she went back into the building. She stated she did not get very far into the facility when Van Driver #5 came in and told her there were no brakes on the van. Van Driver #2 stated they walked toward the entrance doors and noticed the van was moving. Van Driver #2 stated the van made a slight turn and they ran to try and catch it. Van Driver #2 stated the van went up a curb, knocked down a fence, went up another curb, down the hill, across the road and stopped in the woods. Van Driver #2 stated they were not able to catch up with the van to stop it. Van Driver #2 stated she went inside to have someone call 911 while Van Driver #5 went to the scene of the accident. Van Driver #2 stated after informing staff to call 911 she went to the scene of the accident. Van Driver #2 stated she saw Van Driver #5 turn off the engine of the van when she arrived at the scene of the accident. Van Driver #2 stated that since the accident she had not transported any residents and that she had not met with the administrator to discuss any changes that would go into effect as a result of the accident.	F 323		

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F 323	Continued From page 9 In a follow-up interview on 4/27/11 at 1:40 PM Van Driver #2 stated she was not aware that part of training a new driver included observing them drive the van because it was not a part of the Skilled Sheet For The Van Driver. Van Driver #2 also stated she was not aware if there was a policy about supervision of residents. On 4/27/11 at 9:20 AM Van Driver #5 stated prior to 4/17/11 he rode in the van a couple times with Van Driver #1. Van Driver #5 stated he was shown all the safety features, how to perform the Daily Van Safety Checklist prior to use and how to secure a resident in the facility van. Van Driver #5 stated he had not driven the van prior to 4/17/11. Van Driver #5 stated about 1:30 PM on 4/17/11 he was asked if he could transport a resident to the emergency room. Van Driver #5 stated he moved the facility van to the front entrance and Van Driver #2 assisted him to secure Resident #1 in the van. Van Driver #5 stated Van Driver #2 went back into the facility after Resident #1 was secured in the van. Van Driver #5 stated he got in the van and pushed the brake pedal down to check the brakes. Van Driver #5 specified that the two times he pushed the brake pedal it felt "mushy" and "went to the floor". Van Driver #5 stated he got out of the van and went into the facility to find Van Driver #2 to have her look at the brakes. Van Driver #5 stated he was in the building at the most, for a minute and a half. Van Driver #5 stated when he left the van it was running and it was in park with the emergency brake engaged. Van Driver #5 stated when he and Van Driver #2 got to the front door they could see the van was moving and ran to try and stop it as they could see it was headed for the hill at the front of the facility. Van Driver #5	F 323		

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	345193	A. BUILDING _____ B. WING _____	C 04/28/2011

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F 323	Continued From page 10 stated when he got to the van he checked to see that the resident was okay and turned the engine off. Van Driver #5 stated he checked the emergency brake and it was still engaged and the gear shift was in park. Van Driver #5 could not explain what happened to cause the van to roll from the parking lot approximately 230 feet. Van Driver #5 stated he had been told in training to never leave a resident unsupervised. He stated he had been told to call 911 if something happened to the resident during transport and to call the mechanic shop if mechanical problems were suspected. On 4/27/11 at 9:50 AM the Administrator stated he still didn't know what the problem was that caused the accident because he was waiting to receive the findings from the insurance company but the insurance company had not yet sent out an adjustor. Upon further questioning, the Administrator acknowledged that the owner of the garage had checked out the brakes and was unable to find anything wrong with them. The Administrator further stated that typically the senior van driver, Van Driver #1, would do all the training. The Administrator stated there was not a written protocol on what would be included in training other than what is on the Skilled Sheet for the Van Driver. He stated it was his expectation that the new van driver should drive the van in the presence of the trainer even though it was not included on the Skilled Sheet for the Van Driver. The Administrator stated that a resident should never be left alone in a vehicle and that the drivers should use their mobile phone to call for assistance, even if they are in the facility parking lot. The Administrator stated he did not speak to Van Driver #5 about specific details of the	F 323		

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F 323	Continued From page 11 accident. On 4/27/11 at 10:30 AM the Administrator acknowledged that he had not implemented corrective actions for two of the contributing factors of the 4/17/11 van accident which included; the van driver leaving a resident unsupervised and unattended while the resident was in the vehicle and not including supervised driving as part of the orientation for new van drivers. The Administrator was notified of the immediate Jeopardy on 4/27/11 at 10:30 a.m. The facility provided a credible allegation of compliance on 4/28/11 at 4:59 p.m. The following interventions were put into place by the facility to remove the Immediate Jeopardy: Resident #1 was assessed by the RN Supervisor and monitored by staff until Emergency Management Services arrived. EMS transported Resident #1 to the hospital for evaluation. Later the same day the resident returned with no new orders and no apparent injuries. Resident #1 will receive continual supervision with all transports by the van driver. On April 28, 2011 the Administrator conducted an audit of all other interviewable residents transported via the facility van since January 01, 2011. The audit included interviews with residents to determine if any other resident was affected by the deficient practice. The findings from this audit revealed that no other resident was affected by the deficient practice. Facility residents will receive continual	F 323		

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F 323	Continued From page 12 supervision by the van driver during transports. The van was immediately taken out of service and sent to a local garage for inspection and has not been driven since April 17, 2011. On April 27, 2011 and April 28, 2011 all van drivers were inserviced by the Safety Director, the Administrator, and the Director of Nursing on the importance of not leaving a resident unattended in the van. They are to use a cell phone after bringing the van to a complete stop in a safe area. Also, van drivers were instructed that prior to exiting the van the driver will place the van in park, engage the emergency brake and turn the van off. Wheel chocks are to be used under the front and back of a tire the minute the van driver exits the vehicle. On April 27, 2011 the Van Transfer Policy was updated to reflect that the resident is not to be left unattended in the van; if the van driver requires assistance they are to stop in a safe area and use a cell phone to call the facility or to call 911. Wheel chocks are to be used under the front and back of a tire as soon as the van driver exits the vehicle. Three permanent signs will be posted in the van that state "Never leave resident unattended" in large bold letters. These signs will be posted on the dash, on the right inside of the rear door, and on the back of the lift. New van drivers will have orientation on the safe operation of the van by the senior driver and skills will be checked off. The skills checklist has been updated to reflect that new van drivers will drive	F 323		

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F 323	Continued From page 13 the van to a minimum of five appointments under the supervision of an experienced van driver. The skills check list now includes to never leave a resident unattended, to use a cell phone to call for assistance, and to use wheel chocks immediately upon exiting the van. All current drivers were retested on the skills checklist on April 28, 2011 by the Safety Director. All current drivers passed the test. On April 27, 2011 all van drivers were inserviced by the Safety Director, the Administrator, and the Director of Nursing on the importance of never leaving a resident unattended in the van. They are to use a cell phone after bringing the van to a complete stop in a safe area. Also, van drivers were instructed that prior to exiting the van the driver will place the van in park, engage the emergency brake and turn the van off. Wheel chocks are to be used under the front and back of a tire the minute the van driver exits the vehicle. Three permanent signs will be posted in the van that state, "Never leave resident unattended" in large bold letters. These signs will be posted on the dash, on the right inside of the rear door, and on the back of the lift. Wheel chocks will be placed under the front and back of a tire any time the van is parked to load or unload a resident. Monthly Q/A of the van preventative maintenance safety checklist will be review by the senior van driver, the Safety Director, and Administrator for compliance.	F 323		

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F 323	Continued From page 14 The Director of Nursing or the Safety Director will do a weekly ride-along audit of van/personal vehicle safety, that a resident is never unattended, the experience of the driver, the signs are in the van, and chocks are used under the front and back of a tire when loading or unloading residents. During these audits the van drivers will also be observed to ensure that they place the van into park, set the emergency brake and turn the van off prior to exiting the vehicle. The Administrator will monitor the audit for compliance and provide a monthly report to the QA committee for review and appropriate follow-up action if indicated. On April 27th, 2011 the Van Transfer Policy was updated to reflect that the resident is never to be left unattended in the van; if the van driver requires assistance they are to stop in a safe area and use a cell phone to call the facility or to call 911. Wheel chocks are to be used under a front and back tire immediately when the van driver exits the vehicle. In interim until the van is back in service residents with outside facility appointments will be transported to appointment by: 1. If resident is ambulatory, transport will be by a designated van driver in their personal vehicle. The ambulatory resident's family members can transport if they are willing to transport in their personal vehicle. 2. If resident is non-ambulatory, transport will be by non-emergency transport (name of local county EMS). For the associate that transports with their	F 323		

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F 323	Continued From page 15 personal vehicle, a vehicle safety check and a skill sheet for that driver will be reviewed by the Safety Director before they are allowed to transport residents in their personal vehicle. The same policy as the van policy will be followed. The one personal vehicle that has the possibility of transporting residents was inspected by the facility's Safety Director to verify the safety of the personal vehicle used for resident transport. This inspection included reviewing and obtaining a copy of the registration card, the vehicle inspection statement, and all maintenance records for the personal vehicle used for resident transport. Copies of these records will be kept on file in the Safety Director's office. The Safety Director checked the vehicle with the Personal Vehicle Safety Checklist that includes directional signals, functioning seat belts, functionality of the brake pedal, headlights, brake lights, windshield wipers, horn, tires, and emergency flashers on the personal vehicle used for resident transport. Skills check list has been updated to reflect that new van drivers will drive the van to a minimum of five appointments under the supervision of an experienced van driver. The skills check list now includes to not leave a resident unattended, to use a cell phone to call for assistance, and to use wheel chocks immediately upon exiting the van. Three permanent signs will be posted in the van that state "Never leave resident unattended" in large bold letters. These signs will be posted on the dash, on the right inside of the rear door, and on the back of the lift. All van drivers will be inserviced every six months	F 323		

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F 323	Continued From page 16 by the Safety Director, the Administrator, and the Director of Nursing on the importance of never leaving a resident unattended in the van. They are to use a cell phone after bringing the van to a complete stop in a safe area. Wheel chocks are to be used under the front and back of a tire as soon as the van driver exits the vehicle. The Director of Nursing or Safety Director will do random weekly checks of van safety for three months or until substantial compliance is achieved then monthly. Any areas of concern will be addressed immediately and reported to the QA Committee. The Director of Nursing or Safety Director will do random weekly ride-along checks on residents in the van for three months, then monthly for three months or longer until discontinuation approved by the QA Committee. Any areas of concern will be addressed immediately and reported to the QA Committee for review. The Director of Nursing or Safety Director will check new van drivers' orientation before releasing a driver to transport residents without an experienced van driver. The Administrator will monitor the random checks for compliance and provide a monthly report to the QA committee for review and appropriate follow-up action if indicated. The Immediate Jeopardy was removed on 4/28/11 at 6:45 PM. The audit of all interviewable residents had been completed and determined no other residents had ever been left unsupervised or felt unsafe during transport. The facility had	F 323		

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F 323	Continued From page 17 revised the van policy and included supervising residents at all times during transport, the use of wheel chocks and procedures to take if there are suspected mechanical problems with a vehicle. The safety sheet for the one personal vehicle used in the interim for ambulatory resident transport included the registration card, inspection statement, all maintenance records and the personal vehicle safety checklist. The revised Skilled Sheet For The Van Driver included a new driver must be observed driving the van five separate times before driving independently, supervision of residents and procedures to take if there are suspected mechanical problems with a vehicle. The records were reviewed to ensure all drivers had been retested on the skill sheet. Inservice records were reviewed and all drivers were in attendance for review of the new policies and procedures. The signs to be placed in the facility van were available for immediate use. Wheel chocks had been purchased and all van drivers were interviewed and were aware to use them whenever a vehicle was not in motion. Van drivers were able to verbalize understanding of the new policies and procedures including changes to training, supervision of residents and procedures to take if there were suspected mechanical problems with a vehicle.	F 323		