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| F 323 SS=J | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to individualize the securement of Resident #110 by achieving angulation of the seat belt across the resident as specified in the owner's manual for 1 of 1 sampled residents (Resident #110) who sustained injury in the facility transportation van. The resident slid out of her wheelchair during transport and landed on the floor of the van | F 323 | F323<br>1. Corrective Action taken for affected resident<br><br>Resident #110 was provided contract transport services for necessary appointments beginning 5/4/17 until resident #110 discharged from facility on 5/5/17. | 5/22/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/23/2017

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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sustaining a hematoma, skin tears, swelling, and bruising. Based on observation, staff interviews and record review the facility also failed to maintain water temperatures below the acceptable temperature of 116 degrees Fahrenheit for 1 (short hall) of 3 halls. The immediate jeopardy (IJ) began on 04/20/17 when the facility transporter applied brakes and swerved to avoid a head-on collision, causing the resident to slide out of her wheelchair and sustain injuries when she hit the floor of the van. The IJ was removed on 05/05/17 at 12:05 PM when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to allow the facility to monitor and implement its new procedure for individualizing the wheelchair securement of residents in the facility transportation van. The facility also remained out of compliance because of hot water issues also cited at F323, but with a scope and severity of E.
Findings included:

1. The facility's 2017 transit van owner's manual documented, "Position the safety belt height adjuster so that the safety belt rests across the middle of your shoulder. Failure to adjust the safety belt correctly could reduce its effectiveness and increase the risk of injury in a crash."

Review of a Vehicle Safety Competency, dated 03/21/17, revealed the facility transporter passed the competency and met safety standards and procedures for: preparing residents for loading, loading/unloading residents on a lift, understanding and following manufacturer's guidelines for weight limits/safety

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On 5/1/17, Maintenance Director shut off water to rooms 308, 306, 300, 301, 310, and 303 and taped sinks to prevent staff and/or resident use. Contacted local plumbing service 5/1/17 and mixing valves were installed. Water temperatures in rooms 308, 306, 300, 301, 310, and 303 were checked by the Maintenance Director after mixing valves were installed on 5/1/17 and temperatures were below 116 degrees.

2. Other residents with the potential to be affected

Residents requiring facility transport have the potential to be affected. Current resident census was reviewed by DON, ADON and appointment scheduler on 5/4/17 to identify residents that require transportation on the facility van through 5/19/17. DON, ADON, and appointment scheduler will continue to identify residents requiring contract transport service weekly until facility van is placed back in service.

Residents residing in the facility have the potential to be affected by this finding. Maintenance Director and/or designee will check water temperatures in resident rooms daily to ensure compliance. Staff were in-serviced on 5/1/17 on procedure for identifying possible non-compliant water temperatures in resident rooms. Staff were instructed to immediately report to the Maintenance Director any water temperatures they suspect may be too

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precautions/maintenance, proper placement of resident wheelchairs in the van, proper securement of resident wheelchairs with tie downs, proper placement of the seat belts to secure residents in their wheelchairs, and utilizing precautions and following safety guidelines. The form revealed the transporter was evaluated by the maintenance manager (MM).

Record review revealed Resident #110 was admitted to the facility on 04/19/17. The resident's documented diagnoses included osteoarthritis, end stage renal disease with hemodialysis, anxiety, peripheral vascular disease, atherosclerotic heart disease, asthma, diaphragmatic hernia, and encephalopathy.

Review of a 04/20/17 Pre-Trip Vehicle Safety Inspection Checklist revealed the facility transporter checked off "Seat belts and wheelchair tie-downs work properly for driver and passengers" and "All passengers must wear seat belts and, if in wheelchair, must also have wheelchair tie-down" prior to transporting Resident #110 in the facility's 2017 transit van.

A 04/20/17 7:49 PM progress note documented, "During transport from dialysis to facility transport vehicle was run off the road by an on-coming vehicle at 5:35 PM. Transport driver called 911 to have them come to evaluate the resident. When brakes applied to swerve out of way of on-coming vehicle, the resident fell from the chair with seatbelt still on. Res (Resident) had skin tear to right hand and right cheek as well as a lump to her right forehead about marble size. Res remained alert and oriented and stated she was in no pain. Transport driver then called facility to inform us of description of incident. ____ (name

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hot.

3. What measures will be put into place or what systemic changes

"Manufacturer of van safety equipment Customer Service (800-987-9987) was contacted May 4, 2017. Height adjuster, New Straps, Decal giving a visual example of proper application of safety restraints and Training Video received on 5/8/17.
"Height adjuster, New Straps were installed in facility van by local Auto Service technician 5/9/17. Van driver view manufacturer□s training video on 5/10/17. Prior to providing resident transportation staff involved in the transportation of residents will view the training video provided by manufacture of van safety equipment on the proper fitting and application of all safety restraints The maintenance director provided a hands-on training with return demonstration competencies for transportation staff based on the manufacturer□s guide lines 5/11/17 thru 5/14/17.This will be completed on an annual basis or with new hire van drivers by the Maintenance Director. Van driver will complete a safety restraint checklist for all residents who utilize the facility van for transportation. The van driver will monitor for proper application of safety restraints prior to ignition. Residents will be evaluated utilizing safe seat belt practices that include: shoulder belt crosses between shoulder and neck, lower back against

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of primary physician) was then notified at 5:45 PM. The family (name provided) was then notified at 5:50 PM. Res was transported to ____ (name of hospital). When transport arrived back at center the van was inspected by maintenance to verify proper placement of equipment."

04/20/17 emergency department notes documented, "...Large hematoma noted to pt's (patient's) right orbit (eye socket). Bleeding controlled." Primary diagnoses included contusion of face, right periorbital ecchymosis (bruising to right eye), right facial abrasion, right foot contusion, and superficial laceration to left hand. Computed tomography (CT) and x-rays ruled out fractures to the head, spine, feet, and hands.

A 04/20/17 statement from the transporter as taken by the police department, after the transporter returned to the facility, documented, "...A car in the opposite lane was passing another car and coming at us head on. I had to swerve to prevent them from hitting us head on....(Resident #110) fell out of the wheelchair onto the floor, her wheelchair did not move nor did her seat belt come loose. They both were safely secured. She fell on the side of her face. I immediately checked to see if (Resident #110) was ok, then called 911, she was bleeding on the side of her face and on her hand. She was alert and talking to me. I was keeping an eye on her physical appearance and providing emotional support until the ambulance arrived. When the ambulance arrived they checked (Resident #110) who was still bleeding and alert, took her to the hospital...." In this statement the transporter reported she was traveling at about 35 miles per hour at the time of the van incident.

seating device, lap belt on upper thighs and knees bent at edge of seat, to ensure proper securement a visual aid is posted inside van on interior wall demonstrating proper placement of safety restraints. "Maintenance director will perform random audits using safety restraint checklist based on van driver□s daily transport schedule 3 x per week for four weeks and then monthly for six months to ensure proper use of safety restraints in accordance with manufacturer□s guidelines.

"Maintenance Director and/or designee will check and document water temperatures in resident rooms daily for 4 weeks, then five random resident rooms daily for four weeks and then weekly water temperatures according to facility policy. The Administrator will review water temperature logs weekly for 4 weeks, then monthly with the Maintenance Director to ensure water temperatures remain in compliance.

4. Monitoring of Corrective Action

"Results of these audits will be reviewed monthly x 3 months by facility QAPI committee to ensure continued compliance.

Results of these water temperature audits and reviews will be reviewed by the facility□s QAPI committee monthly x 3 months to ensure continued compliance.

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A 04/21/17 3:03 AM change in condition follow-up note documented, "Right eye purple swollen shut. 2nd and 3rd fingers right hand from tips to 2nd knuckles purple in color. Monitored for mental status changes. c/o (complaints of) pain refused any pain meds."

A 04/21/17 10:20 PM progress note documented, "...right eye closed and swollen and entire right side of face bruised, discolored, and swollen. Pts (Patient's) right hand and fingers swollen black and blue middle finger and index fingers. Pt able to move all fingers and extremities well...."

On 04/21/17 "Resident at risk for falls r/t (related to) limited mobility and weakness. 04/20/17 fall with injury and ER (emergency room) visit with bruising and swelling to rt (right) eyes, skin tears to rt hand and rt cheek" was identified as problem in Resident #110's care plan. Interventions for this problem included involvement of physical therapy and occupational therapy to help improve the resident's strength and mobility.

The resident's 04/26/17 admission minimum data set (MDS) documented her cognition was moderately impaired, she exhibited no behaviors including resistance of care, and she required extensive assist by two staff members with transfers. The assessment also documented Resident #110 was not steady during transitions/transfers and walking, she had no impairment in her range of motion, she utilized a walker and a wheelchair for mobility, she had skin tears and moisture associated skin damage, and she was receiving occupational and physical therapy.

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At 10:45 AM on 05/3/17 Resident #110 stated she remembered van brakes being applied and the van swerving off the road, but she could not remember how or if she was secured in the van on 04/20/17 when the transporter picked her up from dialysis to return her to the nursing home. However, she commented if she was "belted in" as required she did not understand how she could have come out of her wheelchair. She recalled being on the floor of the van on her side.

At 10:45 AM on 05/03/17 the facility's supply clerk/transporter stated she assumed the transporter position on 04/04/17. She reported she received training from the MM (on 03/21/17) before she transported any residents. She commented most of the training was hands-on, but she did get some written information to refer to also. According to the transporter, the MM showed her the proper technique for securing wheelchairs with tie downs and for applying seat belts. She also commented the MM reviewed the Pre-Trip Vehicle Safety Inspection Checklist, the vehicle operation and routine operation of van features, and the need to carry a first aid kit and disinfectant spray. She explained that before she could begin transporting residents she had to perform acceptable return demonstration of loading and unloading residents, wheelchair securement, seat belt placement, and completion of the inspection checklist. The transporter stated on 04/20/17 Resident #110's wheelchair was secured at four points, her wheelchair was locked, and her seatbelt (combination belt across shoulder and lap) was fastened. She reported she completed the Pre-Trip Vehicle Safety Inspection Checklist before pulling away from the dialysis center. The transporter stated she had begun slowing down on a two lane road to make

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| F 323 | Continued From page 6<br>a turn, but as she looked ahead she saw a car coming at the van head on as it was trying to pass another vehicle. She reported she had to swerve off the road and apply brakes to prevent a head-on collision. When the van came to a complete stop the transporter commented she observed Resident #110 on her right side on the floor. She stated the wheelchair was still secured at four points and the seatbelt was still fastened, but the resident had come out of the wheelchair. She reported the resident was bleeding from her right hand and right cheek. She commented she called 911 first and then the facility. According to the transporter, the resident was still alert and oriented and did not complain of any pain, but the ambulance arrived at the accident site and took the resident to the hospital. She commented the police did not come to the site of the accident because they reported there was no crash. She stated once the resident was taken away to the hospital, she returned to the nursing home where the MM was waiting on her. She reported the MM immediately inspected the van, including the seatbelt and wheelchair tie downs, and the resident wheelchair which was still secured in the van at four points, but found nothing wrong. She stated the MM requested that she secure him in a wheelchair, and required that she demonstrate how she loaded and secured Resident #110 in the van. She commented the MM took her out driving, remaining secured in the wheelchair, making her apply breaks, swerve, and make turns. She reported the MM remained secured in the wheelchair without any problems during the entire trip.<br><br>At 11:02 AM on 05/03/17 the administrator of the facility at the time of the 04/20/17 van incident stated the van was a brand new 2017 transit van, | F 323 | | |

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| F 323 | Continued From page 7<br>received by the facility in October 2016. She reported Resident #110 was the only resident transported in the facility van on 04/20/17. She commented the facility thought Resident #110 would be hospitalized overnight for observation after the van incident, but four or five hours after the incident the emergency room (ER) contacted the facility, informing them that the resident was ready for discharge. According to the administrator at the time of the incident, the facility's transit van was used to pick Resident #110 up from the ER. She explained that the MM had found no problems during his post-incident van inspection, and the facility did not want to bother the resident's family by asking them to pick the resident up from the hospital. (Review of transit records also revealed the facility van was used to transport Resident #110 back and forth to dialysis on 04/25/17, 04/27/17, and 05/02/17). According to the administrator, she also had the MM take the van to a certified mechanic who verified the seat belts and wheelchair tie downs were in good working condition. (A copy of the auto service invoice was reviewed). She commented after the incident she had the MM interview all alert and oriented residents who had been transported in their wheelchairs in the van recently, and all of them reported the transporter used a seat belt and four point tie downs to secure them in their wheelchairs. None of the residents had concerns about their safety. The administrator stated during facility interviews with Resident #110 the resident mentioned she thought maybe the transporter missed a turn and that was why she applied brakes and swerved so the facility made pictures of the incident scene which showed no tire tracks in the road and undisturbed grass where the transported pulled off the road. As a precaution the administrator | F 323 | | |

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also reported the transporter passed an on-line defensive driving course on 04/26/17. (A copy of the course transcript was reviewed).

At 11:36 AM on 05/03/17 the MM stated during the transporter's initial competency she had to demonstrate safe driving skills and safe securement of residents in wheelchairs by using the seat belt and four point tie downs. He reported he also did monthly inspections of the transport van to make sure the seat belts and tie downs were in good working condition, and there had been no problems discovered. (These monthly inspections were reviewed with the last inspection taking place on 03/31/17).

At 1:12 PM on 05/03/17 during an observation the facility transporter secured Resident #64 in the facility transit van. The resident was in her personal wheelchair, and the transporter secured her in the van using a seat belt and four point tie downs. The seat belt crossed the resident's shoulder at the mid-point (the resident had broad shoulders), and fit securely around the resident's body. (On 05/04/17 Resident #64's weight summary documented she was 64 inches tall and weighed 197 pounds). The resident was still secured safely in her wheelchair when the van arrived at the doctor's office after the transporter maneuvered curves, hair pin turns, and broken pavement.

At 3:50 PM on 05/03/17 physical therapist (PT) #1 stated she was currently working with Resident #110 to improve her lower extremity strength, balance, ambulation, transfers, and wheelchair mobility. She reported the resident was making good progress. She commented, for example, the resident was now able to ambulate 250 feet

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with contact guard and a rest break, was able to endure 20 minutes of cardio exercising, and her trunk stability was good when sitting up. According to PT #1, she was not the PT who completed the resident's initial evaluation, but she thought she remembered the resident being very weak from a hospitalization for pneumonia.

At 9:25 AM on 05/04/17 an electronic search revealed the van manufacturer reported no recalls on the model being used by the facility.

At 10:16 AM on 05/04/17, during a telephone interview, a customer service representative for the company which manufactured the securement system in the facility transport van stated if the van was being used to transport a large number of residents with varying body types it was very important to individualize seat belt placement to achieve the safest angle at which the seat belt crossed the residents' bodies. He reported the standard was for the seat belt to cross the middle of the residents' shoulders which maximized the belt's ability to keep the residents seated. He commented he thought this standard was documented in the owner's manuals which accompanied the vans when they were purchased. According to the representative, it was difficult to achieve these effective seat belt angles without some type of device to regulate the height at which the seat belt began its decent across the resident's body. (The facility's 2017 transit van owner's manual documented, "Position the safety belt height adjuster so that the safety belt rests across the middle of your shoulder. Failure to adjust the safety belt correctly could reduce its effectiveness and increase the risk of injury in a crash.")

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At 10:32 AM on 05/04/17 the administrator at the time of the van incident stated the facility van did not have any device to help regulate the angle at which the seat belt crossed resident bodies, and she was not aware that devices such as height adjusters were available. She explained the facility received the van in October 2016 from corporate so the facility had no interaction with the dealership where they might have mentioned devices that could be purchased to make securement more effective.

At 11:18 AM on 05/04/17 the facility transporter secured Resident #110 in the transport van. The resident was in her personal wheelchair, and the transporter secured her in the van using a seat belt and four point tie downs. The seat belt crossed the resident below her shoulder, just below the mid-upper arm. The transporter confirmed that this was the way Resident #110 was secured on 04/20/17. (A 04/25/17 entry in Resident #110's weight summary documented she was 62 inches tall and weighed 108.5 pounds.) The resident had very small, thin, raised shoulders. The MM attempted to improve the angle at which the seat belt crossed the resident's body by moving the four point tie downs, but then the seat belt either cut into the resident's neck or fell completely off her shoulder. The MM stated he did not have the angulation problem when the transporter secured him in the van on 04/20/17, but he was about 70 inches tall and weighed about 204 pounds. The MM reported he had never observed Resident #110 secured in the facility van.

At 12:35 PM on 05/04/17 the administrator at the time of the van incident stated the facility had not placed Resident #110 in the transport van to

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observe how she was secured as they were formulating their 04/20/17 post-incident action plan.

At 1:30 PM on 05/04/17 PT #2, who completed Resident #110's initial physical therapy evaluation, stated during a telephone interview that she completed the initial eval before the resident left for dialysis on 04/20/17. She reported the resident was very weak, could only stand holding onto a rollator, and was unable to walk any at all. She explained that at this point in time it would have been necessary to transport the resident in her own wheelchair in the facility van.

At 3:32 PM on 05/04/17 Resident #110's primary physician stated he was informed of the van incident on 04/20/17, and assessed the resident on 04/26/17. (The physician's progress note was reviewed). He reported upon observation of the resident she had a small hematoma, bruising, and skin tears. He commented the resident's swelling was minimal by the time he observed her. The physician stated he thought the resident's injuries looked worse than what they really were because the resident was on Plavix (A 04/19/17 physician order documented Resident #110 was receiving 75 milligrams of Plavix daily for blood clot prevention). He reported Resident #110 did not complain to him or the staff about uncontrolled pain after the 04/20/17 van incident.

At 3:45 PM on 05/04/17 the facility's social worker stated Resident #110 would be discharged from the facility on 05/09/17, and she would either be going home or to an assisted living facility.

Between 9:32 AM and 10:00 AM on 05/05/17 4 of

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7 residents identified by the facility as being alert and oriented and transported via wheelchair in the facility van from 04/20/17 to 05/04/17 were interviewed (Resident #64 and #110 were not re-interviewed, and one resident had since been discharged from the facility). All residents stated they were secured by the transporter using a seat belt and four point tie down system. All reported they thought the seat belt crossed their bodies about mid-shoulder, and they had no concerns about their safety when in the van. (Resident #24's cognition was intact per a 03/01/17 admission MDS, and was 71 inches tall and weighed 155.5 pounds on 05/04/17. Resident #35's cognition was moderately impaired per a 04/17/17 admission MDS, and was 67 inches tall and weighed 141.5 pounds on 05/04/17. Resident #40's cognition was severely impaired per a 04/09/17 quarterly MDS, and she was 66 inches tall and weighed 222.5 pounds on 05/04/17. Resident #69's cognition was moderately impaired per a 03/31/17 quarterly MDS, and was 66 inches tall and weighed 194 pounds on 05/04/17).

On 05/04/17 at 12:25 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 05/05/17 at 11:50 AM:
Affected Resident
1. Facility will provide Resident #110 with contracted transport services as needed effective 05/04/17.
Other Residents with the Potential to be Affected
1. Facility will provide contracted transport services for all residents until facility transport van is back in service.
2. Resident census reviewed by DON, ADON and appointment scheduler to identify residents

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that require transportation on the facility van on 05/04/17 at 2:00 PM.
3. Manufacturer of van safety equipment customer service was contacted on 05/04/17, and will be sending to the facility the following items: height adjuster, new straps, decal which provides visual example of proper application of safety restraints, and training video. E-mail from representative acknowledged a Monday arrival date 05/08/17.
4. All new parts, height adjuster, new straps will be installed by local auto service technician. Scheduled for 05/09/17.
5. Prior to providing resident transportation staff involved in the transportation of residents will view the training video provided by manufacturer of van safety equipment on the proper fitting and application of all safety restraints. The maintenance director will be responsible for developing a hands-on training with return demonstration competencies based on the manufacturer's guidelines. This will be completed on an annual basis or with the new hire of van drivers by the maintenance director.
6. Van driver will complete a safety restraint checklist for all residents who utilize the facility van for transportation. The van driver will monitor for proper application. Residents will be evaluated utilizing safe seat belt practices that include: shoulder belt crosses between the shoulder and neck, lower back against seating device, lap belt on upper thighs and knees bent at edge of seat, to maintain proper securement. Visual aide will be posted inside van on the van interior wall showing proper placement of safety restraints prior to starting ignition.

The validation of the credible allegation was completed on 05/05/17 at 12:05 PM by doing the

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| F 323 | Continued From page 14<br>following:<br><br>At 11:35 AM on 05/04/17 the MM demonstrated his understanding of the angle at which the seat belt needed to cross resident bodies to ensure safe securement in the facility van.<br><br>At 4:08 PM on 05/04/17 the contract with the facility's contracted transportation services was reviewed and validated.<br><br>At 11:55 AM on 05/05/17 the list of 22 residents who required transport in the facility van was reviewed and validated.<br><br>At 11:57 AM on 05/05/17 an e-mail from the securement system customer representative was reviewed which estimated arrival date of parts, decal, and training video as 05/08/17.<br><br>At 11:59 AM on 05/05/17 it was verified with the MM that an appointment had been set up with local auto service to install new van securement parts on 05/09/17.<br><br>At 12:02 PM on 05/05/17 ad-hoc quality assurance meeting notes were reviewed from 05/05/17 which included re-education about establishing the root cause of incidents/accidents.<br><br>At 12:04 PM on 05/05/17 the facility van keys were observed stored in the new administrator's office drawer where they could not be obtained by other staff. | F 323 | | |

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2. The facility Logbook Documentation for Water Temps was reviewed for January, February, March and April 2017. No temperatures above 116 degrees Fahrenheit were recorded.

On 05/01/17 from 11:00 AM - 12:00 PM the following water temperatures that were above the acceptable temperature of 116 degrees Fahrenheit were taken by the Dietary Manager using the facility self-calibrating air thermometer:

| Room | Temperature |
|---|---|
| 308 | 120 |
| 306 | 122 |
| 300 | 121 |
| 301 | 120 |
| 310 | 122 |
| 303 | 122 |

The facility placed barrier duct tape across the top of all sinks and posted signs not to use the hot water. All residents residing in the above mentioned rooms were not able to access their bathrooms or sinks without staff assistance.

On 05/01/17 from 3:00 PM - 4:25 PM the following water temperatures that were above the acceptable temperature of 116 degrees Fahrenheit were taken by the Dietary Manager and the Administrator using the facility manual thermometer that was calibrated in ice water to 32 degrees Fahrenheit:

| Room | Temperature |
|---|---|
| 308 | 118 |
| 306 | 119 |
| 300 | 119 |
| 301 | 119 |

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310 119
303 119

In an Interview on 05/01/17 at 4:45 PM with the Maintenance Supervisor and the Administrator, the Maintenance Supervisor stated there were no mixing valves on the hot water heaters, only recirculating pumps. He said he turned off the recirculating pumps to cool down the water. He revealed the hot water heaters were already at the lowest setting and could not be further adjusted without the installation of a mixing valve. The Administrator stated she didn't know there wasn't a mixing valve on the hot water heaters. She said she thought these days everyone had a mixing valve. She said the hot water heater was only five weeks old.

An observation was made at 5:30 PM on 05/01/17 that plumbers had arrived and installed a mixing valve.

On 05/02/17 at 2:40 PM the temperature of the water in room 310 was observed to be 120 degrees Fahrenheit taken by the Maintenance Supervisor using the facility thermometer. The Maintenance Supervisor stated he was going to adjust the mixing valve.

An observation on 05/02/17 at 3:45 PM of the water temperatures taken by the Maintenance Supervisor using the facility thermometer calibrated in ice water to 32 degrees Fahrenheit revealed that no temperatures were above the acceptable temperature of 116 degrees Fahrenheit:

Room Temperature
101 107

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| F 323 | Continued From page 17<br>102 108<br>107 108<br>110 105<br>201 110<br>207 110<br>210 108<br>211 110<br>300 112<br>303 109<br>306 110<br>310 110<br>401 109<br>402 110<br><br>In addition, the 100 Hall Shower Room temperature was 110 degrees Fahrenheit.<br><br>On 05/04/2017 at 10:05 AM the facility Logbook Documentation for Water Temps was reviewed and all temperatures recorded were below 116 degrees Fahrenheit.<br><br>In an Interview with Nurse #1 at 10:15 AM on 05/04/17 she stated that she had not experienced the water being too hot and had never known of anyone at the facility to be burned or injured by hot water.<br><br>In an interview with CNA #1 at 10:20 AM on 05/04/17 she stated the water temperatures had not been too hot. Said she never knew of any resident who had been burned or injured from hot water in the facility. | F 323 | | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local | F 371 | | 5/22/17 |

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authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to keep 5 of 6 fluorescent light panels in the kitchen free from a build-up of dust and dirt. Findings included:

During initial tour of the kitchen on 05/01/17, beginning at 11:25 AM, 5 of 6 fluorescent light panels were observed with a build-up of dust and dirt on them. One of these panels was above the 3-compartment sink, there were panels on either side of the steam table, one panel was above the food preparation table, and one panel was above the plate warmer where sanitized plates were stored.

F371
1. Corrective action for residents affected

Dietary Manger and Maintenance Director immediately in-serviced by Administrator on 5/3/17 on proper infection control policy and procedure regarding cleanliness of the kitchen light fixtures. Dietary Manager and Maintenance Director removed grease from light fixtures on 5/3/17.

2. Other residents having the potential to be affected

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During a follow-up tour of the kitchen on 05/03/17, beginning at 8:52 AM, 5 of 6 fluorescent light panels were observed with a build-up of dust and dirt on them. One of these panels was above the 3-compartment sink, there were panels on either side of the steam table, one panel was above the food preparation table, and one panel was above the plate warmer where sanitized plates were stored.

At 9:13 AM on 05/03/17 there was sanitized kitchenware drying on the draining board of the 3-compartment sink system, and the fluorescent light panel above the sink system had a coating of dust and dirt on it.

At 9:20 AM on 05/03/17 carrots were being prepared on the food preparation table. The fluorescent light panel above the prep table had a coating of dust and dirt on it.

At 9:32 AM on 05/03/17 frozen cookie dough was being placed on baking sheets at the food preparation table. The fluorescent light panel above the prep table had a coating of dust and dirt on it.

At 9:45 AM on 05/03/17 plates sanitized by the dish machine were stacked in storage under a fluorescent light panel coated with dust and dirt.

At 11:47 AM on 05/03/17 hot and room temperature foods were on or nearby the steam table. The fluorescent light panels on either side of the steam table were coated with dust and dirt.

At 11:02 AM on 05/04/17 the dietary manager (DM) stated the maintenance department cleaned the fluorescent light fixtures in the kitchen. She

F 371

Residents residing in the facility have the potential to be affected. Dietary Manager and Maintenance Director were in-serviced 5/3/17 by the Administrator on proper infection control policy and procedure regarding cleanliness of the kitchen light fixtures. Dietary staff was in-serviced 5/12/17 by the Dietary Manager on proper infection control policy and procedure regarding cleanliness of the kitchen light fixtures and cleaning schedule for kitchen light fixtures.

3. What measures will be put into place or what systemic changes

Dietary Manager will perform weekly visual inspections of the kitchen light fixtures and clean as necessary x 4 weeks, then monthly. Scheduled cleaning of the kitchen light fixtures was added to the monthly cleaning schedule for the kitchen. Maintenance Director will perform random audits weekly for 4 weeks, then continue monthly per facility policy.

4. Monitoring of Corrective Action

Results of these audits will be reviewed by the facility□s QAPI committee monthly x 3 months to ensure continued compliance.

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| F 371 | Continued From page 20<br>reported she thought the maintenance manager (MM) cleaned them at the same time as he did the vents and sprinkler heads. She commented dust and dirt on the light fixtures posed a risk for cross-contamination because the dust and dirt could fall into food or onto sanitized kitchenware. The DM stated she thought the last time she remembered the light fixtures getting cleaned was in March 2017.<br><br>At 11:18 AM on 05/04/17 the AM cook stated the maintenance department was responsible for cleaning the fluorescent light panels in the kitchen, but she was not sure whether they were cleaned as needed or if they were on a regular cleaning schedule. After looking at the light panels above the food preparation table where she was working, the cook reported dust and dirt could fall into the food she was preparing and make residents sick. She commented she could not remember anyone in the dietary department notifying the maintenance manager that the light panels needed to be cleaned, and she could not remember the last time she observed or was told that the MM had cleaned them.<br><br>At 1:10 PM on 05/04/17 the MM stated the fluorescent light panels in the kitchen were not on a regular cleaning schedule. He reported the last time he was informed by dietary that they needed cleaning was about three months ago, and at that time he used a degreasing solution to remove dust and dirt from them. He commented a monthly inspection of the light panels would probably produce a cleaner work environment in the kitchen. | F 371 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS | F 441 | | 5/22/17 |

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(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism

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| F 441 | Continued From page 22<br>involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review the facility failed to maintain infection control procedures by not washing hands before and after administering eye drops for 1 or 3 residents (#29). Findings included:<br><br>Nurse #2 was observed administering Systane eye drops to resident #29 during the 08:00 AM medication pass on 05/03/17. It was observed that she did not cleanse her hands before or after donning gloves and administering the eye drops. The resident had a diagnosis of dry eyes and was | F 441 | F441<br>1. Corrective action for residents affected<br><br>Nurse #2 immediately in-serviced 5/3/17 by the Director of Nursing on proper infection control policy and procedure on handwashing requirement prior to administration of eye drops after administering oral medications. Education included a competency checklist with return demonstration. | |

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| F 441 | Continued From page 23<br>ordered Systane eye drops, one drop in each eye daily. Prior to administering medications to this resident, Nurse #2 had administered medications to a different resident across the hall and did not wash her hands or use hand sanitizer between residents.<br><br>In an interview with Nurse #2 on 05/03/17 at 10:35 she agreed that she should have washed her hands before and after administering the eye drops and did not.<br><br>In an interview with the Director of Nursing on 05/03/17 at 10:45 AM she agreed that it is the facility policy that hands are cleansed before and after administering eye drops to a resident.<br><br>Record review of the Medication Administration: Eye (Drops and Ointments), Revision Date: 01/02/14, revealed that hands are to be washed prior to donning gloves and after removing gloves when administering eye drops. | F 441 | 2. Other residents having the potential to be affected<br><br>Resident□s receiving eye drops have the potential to be affected. Nursing staff was in-serviced on 5/3/17 by Nurse Practice Educator on facility policy for handwashing prior to administration of eye drops after administration of oral medications. Education included a competency checklist with return demonstration.<br><br>3. What measures will be put into place or what systemic changes<br><br>Director of Nursing and/or designee will perform and document random audits of nurses administering eye drops two times per week for four weeks, then monthly for 2 months to ensure compliance with handwashing.<br><br>4. Monitoring of Corrective Action<br><br>Results of these audits will be reviewed by the facility□s QAPI committee monthly x 3 months to ensure continued compliance. | |
| F 490 SS=J | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced | F 490 | | 5/22/17 |

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F 490

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by:

Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to provide sufficient training to the transporter and her supervisor, the maintenance manager (MM), regarding the individualization of resident securement in the facility van. Lack of training concerning the adjustment of the seat belt angulation based on resident height, weight, and body type resulted in 1 of 1 sampled residents involved in a van incident (Resident #110) receiving a hematoma, skin tears, swelling, and bruising. The immediate jeopardy (IJ) began on 04/20/17 when the facility transporter did not safely secure Resident #110 using a seat belt per instructions in the transit van owner's manual causing the resident to slide out of her wheelchair and sustain injuries when the transporter applied brakes and swerved to avoid a head-on collision. The IJ was removed on 05/05/17 at 12:05 PM when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to allow the facility to monitor and implement its new procedure for individualizing the wheelchair securement of residents in the facility transportation van.

Findings included:

Cross Refer to F323: Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to individualize the securement of Resident #110 by achieving angulation of the seat belt across the resident as specified in the owner's manual for 1 of 1 sampled residents (Resident #110) who sustained injury in the facility transportation van.

F 490

1. Corrective Action taken for affected resident

Resident #110 was provided contract transport services for necessary appointments from 5/4/17 until resident #110 discharged from facility on 5/5/17. Van driver was in-serviced by viewing manufacturer□s training video on 5/10/17. The maintenance director provided a hands-on training with return demonstration competencies for van driver based on the manufacturer□s guide lines 5/11/17 thru 5/14/17.

2. Other residents with the potential to be affected

Residents requiring facility transport have the potential to be affected. Van driver was in-serviced by viewing manufacturer□s training video on 5/10/17. The maintenance director provided a hands-on training with return demonstration competencies for van driver based on the manufacturer□s guide lines 5/11/17 thru 5/14/17. Residents will be evaluated utilizing safe seat belt practices that include: shoulder belt crosses between shoulder and neck, lower back against seating device, lap belt on upper thighs and knees bent at edge of seat, to ensure proper securement a visual aid is posted inside van on interior wall demonstrating proper placement of safety restraints.

3. What measures will be put into place or

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F 490

Continued From page 25

The resident slid out of her wheelchair during transport and landed on the floor of the van sustaining a hematoma, skin tears, swelling, and bruising.

A corporate Vehicle Safety policy, effective 02/01/12 and reviewed on 07/15/15, documented the maintenance manager (MM) was responsible to "educate authorized drivers on use of the company vehicle(s)." The purpose of the policy included, "To provide safe and reliable transportation for patients/residents."

At 12:11 PM on 05/04/17 the facility transporter stated during her initial competency completed on 03/21/17 the MM taught her to verify residents had their seat belts fastened and their wheelchairs secured using a four point tie down system before transporting them in the facility van. However, she reported she never received any instruction about individualizing resident securement so that a safe angulation of the resident's seat belt was achieved.

At 3:18 PM on 05/04/17 the MM stated the facility had provided him with no specialized training in transporting residents. He reported his training consisted of instruction from the maintenance manager at another facility about the importance of making sure seat belts were fastened, and demonstration about how to secure wheelchairs in the facility van using the tie down system. According to the MM, the facility had not provided him with information about how the seat belts should fit across secured van residents that he could pass on to the facility transporter. He explained he thought residents were safe if they were belted in, and did not realize that accidents could happen if the seat belts did not pass across

F 490

what systemic changes

Prior to providing resident transportation staff involved in the transportation of residents will view the training video provided by manufacture of van safety equipment on the proper fitting and application of all safety restraints The maintenance director provided a hands-on training with return demonstration competencies for transportation staff based on the manufacturer□s guide lines 5/11/17 thru 5/14/17. This will be completed on an annual basis or with new hire van drivers by the Maintenance Director. Van driver will complete a safety restraint checklist for all residents who utilize the facility van for transportation. The van driver will monitor for proper application of safety restraints prior to ignition. Residents will be evaluated utilizing safe seat belt practices that include: shoulder belt crosses between shoulder and neck, lower back against seating device, lap belt on upper thighs and knees bent at edge of seat, to ensure proper securement a visual aid is posted inside van on interior wall demonstrating proper placement of safety restraints Maintenance director will perform random audits using safety restraint checklist based on van driver□s daily transport schedule 3 x per week for four weeks and then monthly for six months to ensure proper use of safety restraints in accordance with manufacturer□s guidelines.

4.Monitoring of Corrective Action

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| F 490 | Continued From page 26<br>the mid-shoulder of residents.<br><br>On 05/04/17 at 12:25 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 05/05/17 at 11:50 AM:<br>Affected Resident<br>1. Facility will provide Resident #110 with contracted transport services as needed effective 05/04/17.<br>Other Residents with the Potential to be Affected<br>1. Facility will provide contracted transport services for all residents until facility transport van is back in service.<br>2. Resident census reviewed by DON, ADON and appointment scheduler to identify residents that require transportation on the facility van on 05/04/17 at 2:00 PM.<br>3. Manufacturer of van safety equipment customer service was contacted on 05/04/17, and will be sending to the facility the following items: height adjuster, new straps, decal which provides visual example of proper application of safety restraints, and training video. E-mail from representative acknowledged a Monday arrival date 05/08/17.<br>4. All new parts, height adjuster, new straps will be installed by local auto service technician. Scheduled for 05/09/17.<br>5. Prior to providing resident transportation staff involved in the transportation of residents will view the training video provided by manufacturer of van safety equipment on the proper fitting and application of all safety restraints. The maintenance director will be responsible for developing a hands-on training with return demonstration competencies based on the manufacturer's guidelines. This will be completed on an annual basis or with the new hire of van | F 490 | Results of these audits will be reviewed monthly x 3 months by facility QAPI committee to ensure continued compliance. | |

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| F 490 | Continued From page 27 | F 490 | | |

drivers by the maintenance director.
6. Van driver will complete a safety restraint checklist for all residents who utilize the facility van for transportation. The van driver will monitor for proper application. Residents will be evaluated utilizing safe seat belt practices that include: shoulder belt crosses between the shoulder and neck, lower back against seating device, lap belt on upper thighs and knees bent at edge of seat, to maintain proper securement. Visual aide will be posted inside van on the van interior wall showing proper placement of safety restraints prior to starting ignition.

The validation of the credible allegation was completed on 05/05/17 at 12:05 PM by doing the following:

At 11:35 AM on 05/04/17 the MM demonstrated his understanding of the angle at which the seat belt needed to cross resident bodies to ensure safe securement in the facility van.

At 4:08 PM on 05/04/17 the contract with the facility's contracted transportation services was reviewed and validated.

At 11:55 AM on 05/05/17 the list of 22 residents who required transport in the facility van was reviewed and validated.

At 11:57 AM on 05/05/17 an e-mail from the securement system customer representative was reviewed which estimated arrival date of parts, decal, and training video as 05/08/17.

At 11:59 AM on 05/05/17 it was verified with the MM that an appointment had been set up with local auto service to install new van securement

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| F 490 | Continued From page 28<br>parts on 05/09/17.<br><br>At 12:02 PM on 05/05/17 ad-hoc quality assurance meeting notes were reviewed from 05/05/17 which included re-education about establishing the root cause of incidents/accidents.<br><br>At 12:04 PM on 05/05/17 the facility van keys were observed stored in the new administrator's office drawer where they could not be obtained by other staff. | F 490 | | |
| F 520 SS=J | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and | F 520 | | 5/22/17 |

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| F 520 | Continued From page 29<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to identify the root cause of an accident utilizing its quality assessment and performance improvement (QAPI) process and a performance improvement plan (PIP) which it developed for 1 of 1 sampled residents (Resident #110) who sustained injuries in a van incident. The resident slid out of her wheelchair during transport and landed on the floor of the van sustaining a hematoma, skin tears, swelling, and bruising. Because the facility did not identify the root cause of the 04/20/17 incident, Resident #110 was not safely secured utilizing a seat belt in the facility's transportation van when she was picked up from the emergency room on the night of 04/20/17 and when she traveled back and forth between dialysis on 04/25/17, 04/27/17, and 05/02/17. The immediate jeopardy (IJ) began on 04/20/17 when the facility transporter applied brakes and swerved to avoid a head-on collision, causing the resident to slide out of her wheelchair | F 520 | 1. Corrective Action taken for affected resident<br>The Administrator conducted an ad-hoc QAPI meeting on 5/5/17 to address the identified quality issue for F323 and root cause of incident was identified. Van driver needed additional training.<br><br>2. Other residents with the potential to be affected<br>Residents residing in the facility have the potential to be affected. The Administrator re-educated the facility management team concerning the Center□s QAPI process including need to determine root cause analysis, on 5/5/17. Administrator also provided facility management team with written educational material explaining root cause identification on 5/5/17.<br><br>3. What measures will be put into place or | |

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| F 520 | Continued From page 30<br>and sustain injuries when she hit the floor of the van. The IJ was removed on 05/05/17 at 12:05 PM when the facility's acceptable credible allegation was verified. The facility remained out of compliance at a scope and severity of D (no actual harm with the potential for more than minimal harm that is not IJ) to allow the facility to monitor and implement its new procedure for individualizing the wheelchair securement of residents in the facility transportation van and to educate its QAPI committee members about root cause analysis.<br>Findings included:<br><br>Cross Refer to F323: Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to individualize the securement of Resident #110 by achieving angulation of the seat belt across the resident as specified in the owner's manual for 1 of 1 sampled residents (Resident #110) who sustained injury in the facility transportation van. The resident slid out of her wheelchair during transport and landed on the floor of the van sustaining a hematoma, skin tears, swelling, and bruising.<br><br>Review of minutes from a 04/24/17 Performance Improvement meeting revealed the facility developed a PIP regarding the 04/20/17 van incident involving Resident #110.<br>Recommendations made in this meeting included having the transporter stay at the incident scene until the highway patrol arrived, having the transporter complete a defensive driving course, making pictures of the incident scene, completion of a police report, having the transporter complete another driving competency after the incident, obtaining emergency room reports for Resident | F 520 | what systemic changes<br>The QAPI committee for this facility will meet monthly and ad hoc as needed to identify issues with respect to which quality assessment and assurance activities are necessary to effectively and efficiently attain or maintain the highest practicable physical, mental, psychosocial wellbeing of each resident. The Administrator will use written, on-line and peers for further education of QAPI and to identify root cause analysis. Administrator will provide additional training to QAPI team members to improve process of root cause analysis as need is identified. Administrator will implement use of Root Cause Analysis Tool to ensure thorough investigation and identification of root cause. Facility will also complete QAPI self-assessment tool semi-annually to evaluate the facility□s progress with QAPI process.<br><br>4. Monitoring of Corrective Action<br>Facility will also complete QAPI self-assessment tool monthly x 3 months, then semi-annually to evaluate the facility□s progress and compliance with QAPI process. | |

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#110, and inspecting the seat belt and tie downs in the facility van.

At 11:02 AM on 05/03/17 the administrator at the time of the 04/20/17 van incident stated the 04/24/17 PIP was used as a tool to investigate the cause for Resident #110's injuries. She reported the facility found the van transporter had not done anything wrong, and determined the resident accidentally slipped under the seat belt and into the van floor.

At 2:50 PM on 05/04/17 the director of nursing (DON) stated because of the resident's extensive injuries from the 04/20/17 van incident the facility did not want to disturb her or cause her more pain post-accident by asking her if they could observe her wheelchair securement in the facility transport van.

At 3:32 PM on 05/04/17, during a telephone interview, Resident #110's primary physician and facility medical director stated he attended the monthly quality assurance (QA) meetings, but was not able to be present for the ad-hoc (called for an immediate and special purpose) QA meeting on 04/24/17. However, he reported the facility informed him of the van incident involving the resident within an hour of it happening. He commented he was told the QA committee would be developing a PIP. According to the medical director, the purpose of investigating incidents/accidents was to determine their root cause and how to change facility processes to make sure similar accidents did not happen in the future.

During a follow-up interview with the administrator at the time of the 04/20/17 van incident she

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stated the PIP was the facility's form of root cause analysis. She reported if the facility had extended their investigation a little further by observing Resident #110 when she was secured in the facility van the QAPI committee might have seen that the seat belt did not cross the resident's body at an effective angle to keep the resident safe. She commented the medical director was informed of the 04/24/17 Performance Improvement meeting, but was unable to attend. According to the administrator, the medical director was asked for his post-incident input, and his main focus was addressing the resident's pain/comfort and psychosocial needs.

On 05/04/17 at 12:25 PM the facility was notified of IJ. The facility provided the following credible allegation of compliance on 05/05/17 at 11:50 AM:
Affected Resident
1. Facility will provide Resident #110 with contracted transport services as needed effective 05/04/17.
Other Residents with the Potential to be Affected
1. Facility will provide contracted transport services for all residents until facility transport van is back in service.
2. Resident census reviewed by DON, ADON and appointment scheduler to identify residents that require transportation on the facility van on 05/04/17 at 2:00 PM.
3. Manufacturer of van safety equipment customer service was contacted on 05/04/17, and will be sending to the facility the following items: height adjuster, new straps, decal which provides visual example of proper application of safety restraints, and training video. E-mail from representative acknowledged a Monday arrival date 05/08/17.

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| F 520 | Continued From page 33<br>4. All new parts, height adjuster, new straps will be installed by local auto service technician. Scheduled for 05/09/17.<br>5. Prior to providing resident transportation staff involved in the transportation of residents will view the training video provided by manufacturer of van safety equipment on the proper fitting and application of all safety restraints. The maintenance director will be responsible for developing a hands-on training with return demonstration competencies based on the manufacturer's guidelines. This will be completed on an annual basis or with the new hire of van drivers by the maintenance director.<br>6. Van driver will complete a safety restraint checklist for all residents who utilize the facility van for transportation. The van driver will monitor for proper application. Residents will be evaluated utilizing safe seat belt practices that include: shoulder belt crosses between the shoulder and neck, lower back against seating device, lap belt on upper thighs and knees bent at edge of seat, to maintain proper securement. Visual aide will be posted inside van on the van interior wall showing proper placement of safety restraints prior to starting ignition.<br><br>The validation of the credible allegation was completed on 05/05/17 at 12:05 PM by doing the following:<br><br>At 11:35 AM on 05/04/17 the MM demonstrated his understanding of the angle at which the seat belt needed to cross resident bodies to ensure safe securement in the facility van.<br><br>At 4:08 PM on 05/04/17 the contract with the facility's contracted transportation services was reviewed and validated. | F 520 | | |

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| F 520 | Continued From page 34<br><br>At 11:55 AM on 05/05/17 the list of 22 residents who required transport in the facility van was reviewed and validated.<br><br>At 11:57 AM on 05/05/17 an e-mail from the securement system customer representative was reviewed which estimated arrival date of parts, decal, and training video as 05/08/17.<br><br>At 11:59 AM on 05/05/17 it was verified with the MM that an appointment had been set up with local auto service to install new van securement parts on 05/09/17.<br><br>At 12:02 PM on 05/05/17 ad-hoc quality assurance meeting notes were reviewed from 05/05/17 which included re-education about establishing the root cause of incidents/accidents.<br><br>At 12:04 PM on 05/05/17 the facility van keys were observed stored in the new administrator's office drawer where they could not be obtained by other staff. | F 520 | | |