

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

PRINTED: 09/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2008
NAME OF PROVIDER OR SUPPLIER HERITAGE LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 MORNINGSIDE DRIVE CONWAY, AR 72034	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 224 SS=J	<p>Complaint #13808, substantiated (all or in part) with F224, F309 and F323.</p> <p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13808, substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to ensure policy and procedures were implemented to prevent neglect as evidenced by the facility's failure to ensure the staff member responsible for van transportation demonstrated safe driving skills and safe transportation skills for transportation of residents in the van for 1 of 1 case mix resident (Resident #2) who was transported via wheelchair in the facility van. This failed practice resulted in past Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #2 when the lift was in the down position when off-loading the resident, causing the resident to fall from the van. The facility was informed of the past Immediate Jeopardy on 8/25/08 at 9:52 a.m. The findings are:</p> <p>1. The Facility Van/Vehicle Usage policy received from the Assistant Director of Nursing on 8/21/08 at 9:30 a.m. documented, "...Facility van/vehicle drivers will follow all traffic and motor safety laws and regulations...and obeying speed limits..."</p>	F 224	Past noncompliance: no plan of correction required.	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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

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F 224	<p>Continued From page 1</p> <p>a. An Employee Warning Notice dated 12/27/07 documented the van driver had an Employee Warning Notice for speeding in a hospital parking lot in the facility van. The van driver was written up for, "Violation of safety rules and lack of professionalism." The Action taken, "Final warning." Description of Incident, "Report from staff at [name of hospital] of driving facility van fast in parking area. Police warning for speeding in facility van..." Corrective Action to be Taken, "...Re-inserviced on van and policy [word illegible] and driving."</p> <p>The Police Department Citation Information dated 12/27/07 documented the van driver received a, "Speeding Warning Citation."</p> <p>b. An Employee Warning Notice dated 1/29/08 documented the van driver (name CNA Transportation) was again written up for violation of company rules, violation of safety rules, unsatisfactory work performance and refusal to perform or complete assigned work. She was to be discontinued as the van driver and assigned to the floor. The report documented the van driver had a resident at a doctor's office for an appointment. The resident stated she needed to use the bathroom. The van driver phoned the facility to find out if the resident was a 2 person lift. She was told the resident was a 2 person lift. The van driver then told the doctor, staff and resident that she could not take the resident to the bathroom. "Further violations will result in: Termination. Corrective Action to be taken. What steps will the employee need to take to correct inappropriate work behavior? [Immediate termination had been written in and was crossed out.] D/C [Discontinue] as van driver, move to</p>	F 224			

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F 224	<p>Continued From page 2</p> <p>M-F CNA on the floor."</p> <p>c. On 3/19/08 the van driver signed the Facility Van/Vehicle Usage policy which included, "Retraining on w/c [wheelchair] locks, lifts, loading and ..."</p> <p>2. Resident #2 had diagnoses of Anxiety Disorder, Depressive Disorder, Agitation, Back Pain and Cerebral Arterial Occlusion with Cerebral Arterial Infarction. The Significant Change Minimum Data Set (MDS) dated 7/31/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, mental function varied over the course of the day, repetitive health complaints, resisted care, wheelchair primary mode of locomotion and fell in the past 30 days.</p> <p>a. An OLTC (Office of Long Term Care) Incident And Accident Report submitted on 8/7/08 at 11:00 a.m. documented, "On August 6, 2008 a female resident was transported via facility van to a physicians office for an appointment where they met a family member in the parking lot. The driver of the facility van was a CNA (Certified Nursing Assistant) who had been trained on the policy and procedures of operating the van. Upon the arrival at physician's office the van driver stopped the van got out of the driver side came around to back of the van opened the rear doors and deployed the lift. It is uncertain, however; according to a witness it is reported that she then lowered the lift on down to the ground. The van driver then went around and got in the van with the female resident to release the wheelchair from the locking system inside the van and pushed her out on to the lift and the lift was not in the raised deployed position causing the resident</p>	F 224			

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F 224	<p>Continued From page 3</p> <p>to fall backwards approximately 3 feet to the ground. When the van driver realized the female resident was falling she attempted to catch the resident by grabbing the front arms of the wheelchair. The family member realizing that she was falling ran to try to catch her but did not and then they all fell to the ground. The family member stated that the van driver did not have the lift in the correct position to unload the resident. Resident was seen in the ER (emergency room) for examination to rule out injury. Returned to the facility evening of August 6, 2008 with no new orders."</p> <p>1) On 8/21/08 at 9:19 a.m. the van driver stated, "I've been driving the van about 6 years. I don't have to have a chauffeur's license just a regular license for that van... I was taking [Resident #2] to the doctor's appointment. Her son was meeting us there. I pulled up under the awning at [physician's] office to unload. I got out of the van to open the 2 back doors. After I opened the doors, I remember holding the control to lower and raise the lift. I was talking to the resident's son. I honestly don't remember if I lowered the lift or not. I had 3 other things I had to do that day after I delivered [Resident #2]. It was a crazy day. I honestly don't remember if I lowered the lift or not after I unfolded it... The police came to the accident."</p> <p>2) On 8/21/08 at 9:19 a.m. the van driver stated, "I am not driving the van now. I was on suspension from work until yesterday, until they finished their investigation."</p> <p>b. Physician's Orders dated 8/6/08 documented the resident was to receive Darvocet 100 every 6 hours as needed for pain. Wound care to right</p>	F 224			

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F 224	Continued From page 4 leg. Ice to head four times daily for 24 hours. Monitor abrasions to left elbow every shift for 14 days. Cleanse skin tear to right lower extremity with wound cleanser apply steri strips to approximate edges one time. Cleanse skin tear to right lower leg with wound cleanser, apply triple antibiotic ointment, cover with non-stick Telfa and wrap with Kerlix every day. Cleanse skin tear to right posterior ankle with wound cleanser, apply triple antibiotic ointment, cover with non-adhesive Telfa and wrap with Kerlix. Cleanse skin tear to left shin with wound cleanser, apply triple antibiotic ointment, non-adhesive Telfa and wrap with Kerlix. c. Nurse's Notes dated 8/7/08 at 2:55 p.m., 8/8/08 at 9:00 a.m. and 3:00 p.m. documented the resident complained of pain. The latter being severe neck pain at which time the resident's son requested the resident be sent to ER (emergency room.) The resident returned on 8/8/08 at 5:30 p.m. with orders to resume Darvocet and start a muscle relaxant, Skelaxin. d. Nurse's Notes dated between 8/7/08 and 8/21/08 documented the resident complained of pain (back and/or neck and soreness) 16 times. e. Nurse's Notes dated 8/14/08, 3:00 p.m.-11:00 p.m. shift documented, "New order received for antibiotic for infection to skin tear on ankle. Keflex 500 milligrams three times daily for 7 days." f. On 8/20/08 at 3:18 p.m., the resident was asked about the incident and the resident stated, "I was going to the stomach doctor [name], we got to his place. She [van driver] got out of the van to do her thing to let me out. I was in my	F 224			

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F 224	<p>Continued From page 5</p> <p>wheelchair sitting in that van... First she opened the big doors and she was going to push me out backwards. The big door is on the back of the van. She unlocked me (wheelchair), then she started pushing me backwards. She forgot to pull the lift back up, she left it down. I think she stumbled or something, I went out and she did too... I had a place on the back of my head about the size of my fist. It's just now going away. It's still sore. The wheelchair was on top of me. After I fell, here came her. She fell on top of the wheelchair. My son was there... He tried to catch the wheelchair but couldn't... I could hardly move. I took my first shower yesterday, even my fingers were sore. It hurt my back and head. I get pain pills. I'm 91 years old and they all say I'm tough, I'm a tough cookie..."</p> <p>g. Nurse's Notes dated 8/21/08, 7:00 a.m.-3:00 p.m. shift documented, "...area to right leg - dressing changed and [Doctor] notified that skin tear is not improving..."</p> <p>h. On 8/21/08 at 4:48 p.m. the Assistant Director of Nursing (ADON) received a change of order for Silvadene cream twice daily for right leg skin tear. The ADON was asked if the leg was infected, the ADON stated, "She is receiving antibiotic."</p> <p>3. The facility implemented the following interventions:</p> <p>a. The Unusual Occurrence Report dated 8/6/08 at 2:10 p.m. documented, "Transport via van to MD (Medical Doctor) appoint. (appointment). Van not to be used until sent to dealership. Resident to ER."</p> <p>b. The undated letter from the dealership</p>	F 224			

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F 224	Continued From page 6 documented, "On August 12, 2008 we inspected the lift... The lift was found to be in proper working order with regard to up and down travel and stowing and deploying. We did find the lift to be in need of two torsion bar springs. These springs are used to raise the outer barrier on the platform while lift is in the up - down travel mode..." c. On 8/21/08 at 10:56 a.m., the author of the letter from the van dealership stated, "There is no way the torsion bar springs would cause the lift to fall - never." d. An In-service dated 8/6/08 at 2:30 p.m. documented 54 staff signed off for the updated Van Safety Training using the Facility Van/Vehicle Usage policy. The facility added to their policy, "There is to be two people on the van when transporting residents. Each driver must check behind the other to make sure each resident is securely strapped in properly." Signed by the two new van drivers. "Addendum to Inservice 8/6/08, Two drivers on van will check behind each other to certify that residents being transported will be securely strapped and locked in place as well as lift is in deployed position when loading and/or unloading for a safe transition." e. On 8/25/08 at 9:00 a.m., the Administrator was asked if there was any monitoring for the new policy of having 2 staff members ride the van together and what would happen if one of them was not at work. She stated each shift has a back up staff member who can go on the van or they would call an ambulance.	F 224			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309			

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F 309	<p>Continued From page 7</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13808, substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to ensure ice packs were applied and neuro checks were completed for 1 of 1 case mix resident (Resident #2) who sustained a head injury. This failed practice had the potential to affect 34 residents who were transported in wheelchairs via the facility van according to the Assistant Director of Nursing (ADON) on 8/21/08. The findings are:</p> <p>Resident #2 had diagnoses of Anxiety Disorder, Depressive Disorder, Agitation, Back Pain and Cerebral Arterial Occlusion with Cerebral Arterial Infarction. The Significant Change Minimum Data Set (MDS) dated 7/31/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, mental function varied over the course of the day, repetitive health complaints, resisted care, wheelchair primary mode of locomotion and fell in the past 30 days.</p> <p>a. An OLTC (Office of Long Term Care) Incident And Accident Report submitted on 8/7/08 at 11:00 a.m. documented, "On August 6, 2008 a female resident was transported via facility van to a physicians office for an appointment where they met a family member in the parking lot. The</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>driver of the facility van was a CNA [certified nursing assistant] who had been trained on the policy and procedures of operating the van. Upon the arrival at physician's office the van driver stopped the van got out of the driver side came around to back of the van opened the rear doors and deployed the lift. It is uncertain, however; according to a witness it is reported that she then lowered the lift on down to the ground. The van driver then went around and got in the van with the female resident to release the wheelchair from the locking system inside the van and pushed her out on to the lift and the lift was not in the raised deployed position causing the resident to fall backwards approximately 3 feet to the ground. When the van driver realized the female resident was falling she attempted to catch the resident by grabbing the front arms of the wheelchair. The family member realizing that she was falling ran to try to catch her but did not and then they all fell to the ground. The family member stated that the van driver did not have the lift in the correct position to unload the resident. Resident was seen in the ER for examination to rule out injury. Returned to the facility evening of August 6, 2008 with no new orders."</p> <p>b. The Physician Orders from the hospital dated 8/6/08 documented, Resume previous orders, "...Ice to head 4 times a day for 24 hours."</p> <p>c. The Skin Audit Record dated 8/6/08 documented the resident had a 5 by 6 centimeter (cm) bruise with a 3 by 4 cm raised area in the center on the back of the head.</p> <p>d. The Selected Plan of Care documented a problem dated 8/6/08 of "Fall during transfer in</p>	F 309			

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F 309	Continued From page 9 facility van, at risk for pain and further injury... Approach Text... Neuro checks per MD (Medical Doctor) orders and facility policy..." e. The Treatment Record dated 8/6/08 and 8/7/08 documented the ice was applied to the resident's head twice instead of the 4 times ordered. There was no other documentation in the clinical record that the resident received the ice packs. f. Nurse's Notes dated 8/7/08 at 2:55 p.m., 8/8/08 at 9:00 a.m. and 3:00 p.m. documented the resident complained of pain. The latter being severe neck pain at which time the resident's son requested the resident be sent to ER (emergency room.) The resident returned on 8/8/08 at 5:30 p.m. with orders to resume Darvocet and start a muscle relaxant, Skelaxin. g. Nurse's Notes dated between 8/6/08 and 8/21/08 documented neuro checks were done on 8/6/08 at 8:50 p.m., 8/7/08 at 2:55 p.m., 8/8/08 at 5:30 p.m. and on 8/10/08 no time noted. In 5 days neuro checks were completed 4 times. There was no other documentation in the clinical record that neuro checks were completed for the resident. h. On 8/21/08 at 4:45 p.m., the ADON stated, while looking at the Treatment Record for ice packs, "It's only on there twice. It looks like it was done twice." i. On 8/21/08 at 5:15 p.m., the Administrator stated, "We cannot find neuro checks for the resident. They are usually kept with the MAR (Medication Administration Record)."	F 309			

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F 309	Continued From page 10 j. On 8/22/08 at 11:50 a.m., the ADON provided the Neurological Assessment which documented, "Head Injury/Falls Protocol Neuro checks are to be completed with a complete set of vital signs and documented in the resident's record on the Neuro check flowsheet for all head injuries acquired in the facility. Every 15 minutes x 4, Every 30 minutes x 4, Every hour x 4, Every 4 hours x 2, Every 8 hours x 72 hours or until stable (72 hour minimum).	F 309			
F 323 SS=J	483.25(h) ACCIDENTS AND SUPERVISION 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: Complaint #13808, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure adequate supervision was provided to ensure the staff member responsible for van transportation demonstrated safe driving skills and safe transfer skills for transportation of residents in the van for 1 of 1 case mix resident (Resident #2) who sustained a fall while being off-loaded from the van. This failed practice resulted in past Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #2 when the lift was in the down position when off-loading the resident, causing the resident to	F 323	Past noncompliance: no plan of correction required.		

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F 323	<p>Continued From page 11</p> <p>fall from the van. The facility was informed of the past Immediate Jeopardy on 8/25/08 at 9:52 a.m. The findings are:</p> <p>1. The Facility Van/Vehicle Usage policy received from the Assistant Director of Nursing on 8/21/08 at 9:30 a.m. documented, "...Facility van/vehicle drivers will follow all traffic and motor safety laws and regulations...and obeying speed limits..."</p> <p>a. An Employee Warning Notice dated 12/27/07 documented the van driver had an Employee Warning Notice for speeding in a hospital parking lot in the facility van. The van driver was written up for, "Violation of safety rules and lack of professionalism." The Action taken, "Final warning." Description of Incident, "Report from staff at [name of hospital] of driving facility van fast in parking area. Police warning for speeding in facility van..." Corrective Action to be Taken, "...Re-inserviced on van and policy [word illegible] and driving."</p> <p>The Police Department Citation Information dated 12/27/07 documented the van driver received a, "Speeding Warning Citation."</p> <p>b. An Employee Warning Notice dated 1/29/08 documented the van driver (name CNA Transportation) was again written up for violation of company rules, violation of safety rules, unsatisfactory work performance and refusal to perform or complete assigned work. She was to be discontinued as the van driver and assigned to the floor. The report documented the van driver had a resident at a doctor's office for an appointment. The resident stated she needed to use the bathroom. The van driver phoned the facility to find out if the resident was a 2 person</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>lift. She was told the resident was a 2 person lift. The van driver then told the doctor, staff and resident that she could not take the resident to the bathroom. "Further violations will result in: Termination. Corrective Action to be taken. What steps will the employee need to take to correct inappropriate work behavior? [Immediate termination had been written in and was crossed out.] D/C [Discontinue] as van driver, move to M-F CNA on the floor."</p> <p>c. On 3/19/08 the van driver signed the Facility Van/Vehicle Usage policy which included, "Retraining on w/c [wheelchair] locks, lifts, loading and ..."</p> <p>2. Resident #2 had diagnoses of Anxiety Disorder, Depressive Disorder, Agitation, Back Pain and Cerebral Arterial Occlusion with Cerebral Arterial Infarction. The Significant Change Minimum Data Set (MDS) dated 7/31/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, mental function varied over the course of the day, repetitive health complaints, resisted care, wheelchair primary mode of locomotion and fell in the past 30 days.</p> <p>a. An OLTC (Office of Long Term Care) Incident And Accident Report submitted on 8/7/08 at 11:00 a.m. documented, "On August 6, 2008 a female resident was transported via facility van to a physicians office for an appointment where they met a family member in the parking lot. The driver of the facility van was a CNA (Certified Nursing Assistant) who had been trained on the policy and procedures of operating the van. Upon the arrival at physician's office the van driver stopped the van got out of the driver side came</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>around to back of the van opened the rear doors and deployed the lift. It is uncertain, however; according to a witness it is reported that she then lowered the lift on down to the ground. The van driver then went around and got in the van with the female resident to release the wheelchair from the locking system inside the van and pushed her out on to the lift and the lift was not in the raised deployed position causing the resident to fall backwards approximately 3 feet to the ground. When the van driver realized the female resident was falling she attempted to catch the resident by grabbing the front arms of the wheelchair. The family member realizing that she was falling ran to try to catch her but did not and then they all fell to the ground. The family member stated that the van driver did not have the lift in the correct position to unload the resident. Resident was seen in the ER (emergency room) for examination to rule out injury. Returned to the facility evening of August 6, 2008 with no new orders."</p> <p>1) On 8/21/08 at 9:19 a.m. the van driver stated, "I've been driving the van about 6 years. I don't have to have a chauffeur's license just a regular license for that van... I was taking [Resident #2] to the doctor's appointment. Her son was meeting us there. I pulled up under the awning at [physician's] office to unload. I got out of the van to open the 2 back doors. After I opened the doors, I remember holding the control to lower and raise the lift. I was talking to the resident's son. I honestly don't remember if I lowered the lift or not. I had 3 other things I had to do that day after I delivered [Resident #2]. It was a crazy day. I honestly don't remember if I lowered the lift or not after I unfolded it... The police came to the accident."</p>	F 323			

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F 323	Continued From page 14 2) On 8/21/08 at 9:19 a.m. the van driver stated, "I am not driving the van now. I was on suspension from work until yesterday, until they finished their investigation." b. Physician's Orders dated 8/6/08 documented the resident was to receive Darvocet 100 every 6 hours as needed for pain. Wound care to right leg. Ice to head four times daily for 24 hours. Monitor abrasions to left elbow every shift for 14 days. Cleanse skin tear to right lower extremity with wound cleanser apply steri strips to approximate edges one time. Cleanse skin tear to right lower leg with wound cleanser, apply triple antibiotic ointment, cover with non-stick Telfa and wrap with Kerlix every day. Cleanse skin tear to right posterior ankle with wound cleanser, apply triple antibiotic ointment, cover with non-adhesive Telfa and wrap with Kerlix. Cleanse skin tear to left shin with wound cleanser, apply triple antibiotic ointment, non-adhesive Telfa and wrap with Kerlix. c. Nurse's Notes dated 8/7/08 at 2:55 p.m., 8/8/08 at 9:00 a.m. and 3:00 p.m. documented the resident complained of pain. The latter being severe neck pain at which time the resident's son requested the resident be sent to ER (emergency room.) The resident returned on 8/8/08 at 5:30 p.m. with orders to resume Darvocet and start a muscle relaxant, Skelaxin. d. Nurse's Notes dated between 8/7/08 and 8/21/08 documented the resident complained of pain (back and/or neck and soreness) 16 times. e. Nurse's Notes dated 8/14/08, 3:00 p.m.-11:00 p.m. shift documented, "New order received for	F 323			

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F 323	<p>Continued From page 15</p> <p>antibiotic for infection to skin tear on ankle. Keflex 500 milligrams three times daily for 7 days."</p> <p>f. On 8/20/08 at 3:18 p.m., the resident was asked about the incident and the resident stated, "I was going to the stomach doctor [name], we got to his place. She [van driver] got out of the van to do her thing to let me out. I was in my wheelchair sitting in that van... First she opened the big doors and she was going to push me out backwards. The big door is on the back of the van. She unlocked me (wheelchair), then she started pushing me backwards. She forgot to pull the lift back up, she left it down. I think she stumbled or something, I went out and she did too... I had a place on the back of my head about the size of my fist. It's just now going away. It's still sore. The wheelchair was on top of me. After I fell, here came her. She fell on top of the wheelchair. My son was there... He tried to catch the wheelchair but couldn't... I could hardly move. I took my first shower yesterday, even my fingers were sore. It hurt my back and head. I get pain pills. I'm 91 years old and they all say I'm tough, I'm a tough cookie..."</p> <p>g. Nurse's Notes dated 8/21/08, 7:00 a.m.-3:00 p.m. shift documented, "...area to right leg - dressing changed and [Doctor] notified that skin tear is not improving..."</p> <p>h. On 8/21/08 at 4:48 p.m. the Assistant Director of Nursing (ADON) received a change of order for Silvadene cream twice daily for right leg skin tear. The ADON was asked if the leg was infected, the ADON stated, "She is receiving antibiotic."</p> <p>3. The facility implemented the following</p>	F 323			

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F 323	Continued From page 16 interventions: a. The Unusual Occurrence Report dated 8/6/08 at 2:10 p.m. documented, "Transport via van to MD (Medical Doctor) appoint. (appointment). Van not to be used until sent to dealership. Resident to ER." b. The undated letter from the dealership documented, "On August 12, 2008 we inspected the lift... The lift was found to be in proper working order with regard to up and down travel and stowing and deploying. We did find the lift to be in need of two torsion bar springs. These springs are used to raise the outer barrier on the platform while lift is in the up - down travel mode..." c. On 8/21/08 at 10:56 a.m., the author of the letter from the van dealership stated, "There is no way the torsion bar springs would cause the lift to fall - never." d. An In-service dated 8/6/08 at 2:30 p.m. documented 54 staff signed off for the updated Van Safety Training using the Facility Van/Vehicle Usage policy. The facility added to their policy, "There is to be two people on the van when transporting residents. Each driver must check behind the other to make sure each resident is securely strapped in properly." Signed by the two new van drivers. "Addendum to Inservice 8/6/08, Two drivers on van will check behind each other to certify that residents being transported will be securely strapped and locked in place as well as lift is in deployed position when loading and/or unloading for a safe transition." e. On 8/25/08 at 9:00 a.m., the Administrator was asked if there was any monitoring for the new	F 323			

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F 323	Continued From page 17 policy of having 2 staff members ride the van together and what would happen if one of them was not at work. She stated each shift has a back up staff member who can go on the van or they would call an ambulance.	F 323			