STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. BUILDING _____ B. WING _____	03/05/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARROLLTON HEALTH AND REHABILITATION CENTER	1618 KIRBY RD CARROLLTON, TX 75006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to implement written policies and procedures that prohibit neglect of residents for one (Resident #1) of 14 residents reviewed for accidents. 1. Driver B failed to properly secure Resident #1's wheelchair in the van before transporting the resident to [MEDICAL TREATMENT] on 02/19/14. While being transported the straps securing Resident #1's wheelchair in place came loose and Resident #1 fell backwards in his wheelchair against the rear door of the facility van. Driver B removed Resident #1 from the wheelchair and laid him on the floor of the van, and then transported the resident to the local hospital emergency room . Resident #1 sustained a spinal injury causing paralysis to his legs. 2. The facility failed to properly train facility staff on how to secure residents' wheelchair in the van before transporting residents. An Immediate Jeopardy (IJ) was identified on 03/04/14. While the IJ was removed on 03/05/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of pattern because the facility was still implementing the Plan of Removal. These failures could affect the 13 residents in wheelchairs by placing them at risk for injury while being transported in the facility van by Driver B, which could result in resident injuries, falls, other serious mental/physical harm and/or death. Findings included: Resident #1's MDS assessment, dated 02/01/14, reflected the resident was a [AGE] year-old male, who was admitted to the facility on [DATE], and his [DIAGNOSES REDACTED]. He was 65 inches tall and weighed 242 pounds. The MDS assessment further reflected Resident #1 was able to be understood by others, was not cognitively impaired, and walked in his room and walked in the corridor with the assistance of one person. He was able to transfer himself between surfaces with supervision and the assistance of one person. Resident #1 walked with the use of an assistive device and was able to stabilize himself without the assistance of staff. He had no impairment to his lower or upper extremities. Resident #1's Care Plan, printed 03/04/14, reflected he was a fall risk due to abnormality of gait/balance. The Care Plan did not reflect Resident #1's need for transportation to [MEDICAL TREATMENT] appointments. The facility's Provider Investigation Report, dated 02/25/14, reflected, On February 19, 2014, at approx (approximately) 12:30 PM, (Resident #1) was being transported to a doctor's appointment via the Facility van. The van was being driven by (Driver B). Prior to departing the Facility, (Driver B) secured (Resident #1's) wheelchair in the van, and secured (Resident #1) in his wheelchair; (Resident #1) was seated in the wheelchair near the back of the van. (Driver B) stopped the van on the way to the office at the railroad tracks (street names), at an uphill incline. As the van began moving again, (Resident #1) unexpectedly tipped back in the wheelchair which caused his head to come into contact with the back door of the vehicle. (Driver B) estimated that, at the time of the event, the van was moving at less than 5 miles per hour. In response to the above, (Driver B) immediately pulled the van over into the closest parking lot and tended to the Resident. (Resident #1) was noted to be in his wheelchair, which was tipped at approximately a 30-45 degree angle, with his head still against the door. The back of the wheelchair was strapped securely to the van, and the back wheels were locked into place. The strap for the front right wheel of the wheelchair was no longer attached to the floor of the van; the left front strap, while still connected and strapped to the wheelchair, was observed to be loose. It was (Driver B's) recollection that the straps were secure, in place, and free from obvious or observed defect before he left the faciity on [DATE]. (Driver B) assisted (Resident #1) out of the wheelchair, laid him on the floor of the van. Per his observations at the time, there was no sign of bleeding, bruising, skin discoloration or other visible injury. (Driver B) immediately called the Facility and advised the nursing staff of the event; he was instructed to, and did, take (Resident #1) promptly to the Emergency Department at (local hospital) for further evaluation and treatment.However, immediately following the incident, the two front straps were found to be loose or not secure while the back straps remained in place. Upon further assessment of the vehicle when it returned to the Facility, the pin on the locking mechanism of the right front strap was found to have broken off. Additional investigation revealed that the front straps could be released by the application of pressure, whether from a foot or some other mechanism. Interview with Driver B on 03/04/14 at 12:50 PM revealed on 02/19/14 at 11:15 AM, he was taking Resident #1 to an appointment. He stated he loaded the resident in the van, and the resident was facing the front of the van. Driver B revealed Resident #1 was in his wheelchair which was locked and secured in place by the straps. He stated he stopped at the railroad tracks, and when he accelerated, he saw Resident #1 in the rearview mirror flip backwards. Driver B said Resident #1's head was against the back door of the facility van. He stated he pulled the van over and removed the wheelchair and laid Resident #1 flat on the floor of the van and placed a pillow, which was in Resident #1's wheelchair, underneath his head and contacted the facility. Driver B revealed the nurse told him to take Resident #1 to the emergency room because he was only five minutes away from the hospital. He stated he asked the resident what his pain level was and Resident #1 replied his pain level was at 8. Driver B stated he asked Resident #1 questions from the resident's Face Sheet, for example Resident #1's Social Security Number, and the resident was able to recall the information. Driver B revealed once he arrived at the emergency room , a male nurse came to the van with a flat board, and he assisted the nurse in rolling Resident #1 onto the flat board and carrying the resident into the hospital. He revealed now that he had taken the training regarding transporting residents, he knew he could not transport a resident without a foot rest on the wheelchair. Driver B stated Resident #1 did not have a foot rest on his wheelchair because he would propel himself using his legs. Driver B revealed he had worked at the facility for seven years and had never had a resident fall in the van. He stated he had some training when he first started working at the facility and some training every two years. Driver B revealed following the incident he was suspended for one week. Observation of Driver B on 03/04/14 at 12:50 PM revealed he showed the investigator the inside of the van and how the straps were locked into place inside the van with a locking mechanism. There were four straps that connected to the wheelchair to secure it in place. Two straps in the back and two straps in the front. The straps in the back came up from the floor and hooked onto the lower side of the wheelchair. The right front strap connected to the wall of the van and the left front strap connected to the floor of the van. Driver B stated on the left side of the wheelchair, he had to hook the strap to the front of the wheelchair versus the side of the wheelchair where it would be normally be hooked because Resident #1 had padding wrapped on the wheelchair on the left side. Further interview/observation with Driver B on 03/04/14 at 3:00 PM revealed he demonstrated how Resident #1's wheelchair was secured on 02/19/14, the day of the accident. He explained that normally the straps were supposed to be secured wide to the wheelchair, but since Resident #1's wheelchair was wrapped on the bottom left side with padding, the left front strap was secured to the middle of the wheelchair versus the widest part from the wheelchair to the locking mechanism. Driver B explained he had strapped Resident #1 in the van like that before. He demonstrated on the wheelchair how the two back straps securing the wheelchair were placed on the furthest locking device from the wheelchair and then pulled to secure the wheelchair. By pulling the straps from the widest point from the wheelchair, it created tension allowing the wheelchair to

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) be held in place. Driver B secured the right front side of the wheelchair using the strap and securing it to the furthest locking device located on the wall of the van. When securing the left side of the wheelchair, Driver B placed the strap in the middle locking device located in front of the wheelchair and attached the strap to the middle bar of the wheelchair. The strap placed in the middle of the wheelchair was located where the resident would place his/her feet on the floor. Driver B revealed when Resident #1 fell back in the wheelchair, the middle strap had been released and the right front strap popped out of the lock causing only the back two straps of the wheelchair to remain in place. He demonstrated how the wheelchair was placed when the incident occurred. The wheelchair was leaning against the back door of the van almost parallel to the floor of the van with both of the front straps not attached to the wheelchair. Driver B stated he believed Resident #1 dropped his cell phone and while reaching down to pick the phone up off the floor, stepped on the release mechanism on the strap located in the middle of the chair next to his feet. Driver B stated he did not know why the right front strap came unlocked. He revealed he thought that was what happened because Resident #1 said stupid phone when he (Driver B) went to help him. Interview with the DON on 03/04/14 at 3:20 PM revealed Resident #1 wrapped his wheelchair himself because it was hurting his legs. Resident #1's Nursing Progress Note, dated 02/19/14, reflected Driver B said during transport the resident slid from his seat and complained of his back hurting. Driver B reported he was close to the local hospital emergency room and the resident was taken there. Resident #1's Nursing Progress Note, dated 02/19/14, reflected his family member was notified by the nurse that the resident was at the emergency room . Resident #1's family member informed the nurse he/she was already called by the resident, who said his back was hurting. He/She stated he/she was at the emergency room . Resident #1's family member stated he/she was not aware at that time exactly where the spinal problem was, but the resident would have some type of surgery to repair it that day. Resident #1's Nursing Progress Note, dated 02/19/14, the nurse received a call from the emergency room physician requesting information regarding Resident #1. The note reflected, This nurse told him he can transfer from W/C to bed, Bed to W/Chair, and in the bathroom as well with supervision. Dr said 'PT (Resident #1) is saying now he can not move his legs. If he was not walking independently before, does not look anything is wrong. He should be fine to come back. We are still working with him.' Resident #1's hospital Consultation Report, dated 02/19/14, reflected, .CHIEF COMPLAINT: Quadriparesis (muscle weakness affecting all four limbs).Afterwards he had severe neck pain and he was unable to move his arms or legs. He was brought to the (hospital) emergency room where he was found to have severe weakness of his upper extremities.He had no sensation below approximately C6 dermatome (cervical vertebrae in the neck) and severe numbness above that up to C4 (cervical vertebrae in the neck) .IMPRESSION: Central cord syndrome (acute cervical spinal cord injury) and spinal cord compression (occurs when a mass places pressure on anywhere along the cord) due to cervical stenosis (narrowing of the spinal canal in the neck) and head trauma. PLAN: The patient will immediately be transported to the MRI to undergo an MRI of the complete spine.We will take him back for immediate surgical intervention. He will undergo posterior cervical laminectomy with decompression (surgery to remove the lamina which is a thin plate of bone at the back of the neck that makes up the roof of the spine, rods are then implanted to stabilize the neck) of his spinal cord. Afterwards, he will be observed in the intensive care unit. Resident #1's Consultation Report, dated 02/20/14, reflected, .REASON FOR CONSULTATION: ICU management secondary to [MEDICAL CONDITION] status [REDACTED]. The patient postoperatively is still on the vent support in ICU. On 03/05/14 at approximately 9:30 AM the Investigator went to the local hospital. The Investigator was unable to see Resident #1 due to he was still in ICU with a family member at bedside. Interview with DON on 03/04/14 at 9:15 AM revealed Resident #1 was at the local hospital with multiple fractures sustained from the fall in the facility van. The DON stated since the incident occurred, the facility was no longer using the van and training had been conducted. Interview with Administrator on 03/04/14 at 10:35 AM revealed Resident #1 was currently in ICU at the local hospital, and did not know the resident's exact [DIAGNOSES REDACTED]. The Administrator explained the family communicated to the facility Resident #1 did want to return to the facility on ce he was discharged from the hospital. The Administrator's understanding was Resident #1 leaned over in his wheelchair to pick up his cell phone from the floor of the van and when doing so triggered the release with his foot which released the front strap causing the resident's wheelchair to fall backwards. Interview with Resident #1's Family Member 03/04/14 at 10:57 AM revealed the resident broke his spine, had swollen blood vessels in his spine and blood clots in his arm. The Family Member stated Resident #1 was on a ventilator, the vent was taken out of his mouth and placed it in his throat. He/She explained Resident #1 would never be the same person he was before the accident. The Family Member revealed Resident #1 would never be able to use his legs again. He/She felt the facility should take responsibility for the accident. The Family Member stated he/she felt the facility should have done more regarding looking at the procedure for transporting residents. The Provider Response section of the Provider Investigation Report, dated 02/25/14, reflected, .Van suspended from use for Facility transport, or for any other reason Van scheduled to undergo a full and complete inspection by a qualified outside contractor who specializes in transportation safety restraints and systems. Van driver suspended, pending further investigation.Outside transportation service contracted by the Facility for purposes of patient or other transportation pending van inspection and certification. The Provider Action Taken Post-Investigation section of the Provider Investigation Report, dated 02/25/14, reflected, Van taken in for inspection - updated wheelchair straps installed into van, tested by outside company specializing in transportation safety restraints, and deemed safe and appropriate for use. Training video on resident transport and securing resident in vehicle purchased for use in training all staff involved in resident transportation. Training to be done on hire and annually thereafter, and staff required to successfully pass competency developed in connection with resident safety during transport. Staff will not be permitted to work in transporting residents until they have demonstrated aptitude in this area. One-on-one training to be done with (Driver B), followed by administration of competency on resident safety during transport; (Driver B) will not be permitted to return to work until he has successfully demonstrated aptitude in this area.Training provided to facility staff and van drivers regarding procedures and protocol to follow in the event of a resident emergency, especially as related to a transport situation. An interview with the Administrator on 03/04/14 at 1:30 PM revealed the last training reference on the Provider Investigation Report, dated 02/25/14, would be provided by the corporate office, but it had not started yet. He stated they ordered all new parts for the van. Another interview with the Administrator on 03/04/14 at 3:00 PM revealed the facility did not have a facility manual or a manufacturer's manual on how to properly secure a wheelchair in the van using the straps. The facility's training records reflected Driver B attended Van Safety and Restraints training on 03/03/14. The facility's current undated Resident Securement Training materials reflected the front straps should be anchored on the floor track 3 outside front wheels. 30-45 degree angle. Secure close to seat surface to a welded junction. Ensure track fittings and straps are secure. The back straps should be anchored to the inside of the rear wheels. 30-45 degree angle. Secure straps to welded junction of the wheelchair frame. Ensure track fittings and straps are secure. Interview with Human Resources F on 03/04/14 at 2:02 PM revealed there were no training records regarding transportation for Driver B and there was no department of motor vehicle driving record checks. Interview with the Administrator on 03/04/14 at 3:40 PM revealed he was aware there had not been any trainings regarding transporting residents and no checks of staff, who would be transporting residents, driving records. Further interview with the Administrator on 03/04/14 at 11:34 AM revealed the facility was in the process of developing policies and procedures regarding transporting residents. Prior to the incident, the facility did not have policies and procedures in place regarding transporting residents in the facility van. The Administrator stated the facility van had not been used since the incident on 02/19/14, and new parts had been ordered for the van. The Administrator revealed once the parts arrived, the straps in the van would be replaced. Interview with SW C on 03/04/14 at 3:55 PM revealed she arranged all transportation for residents to their appointments. She stated since 02/19/14, the facility had not transported any residents in the facility van. SW C revealed the facility was using a transportation company to transport the residents to appointments. Interview with SW C on 03/04/14 at 10:30 AM revealed the last time Driver D drove the van was in January 2014. SW C stated Driver D D did not receive training on transporting residents. Interview with Driver D on 03/05/14 at 10:45 AM revealed he had been working at the facility for five years. He stated he was trained on how to strap resident's wheelchairs in the van and transport residents in the van by Driver B. Driver D revealed the first time he drove the van was three or four years ago. He stated he drove residents in the van in January 2014 when Driver B was on leave. The facility's current policy, Abuse Prevention and Reporting, revised May 2007 reflected Neglect was defined as Action or inaction that avoids or prevents physical, mental harm, pain, demonstrates disregard or consequences that may constitute a clear and present danger. An IJ was identified on 03/04/14. On 03/04/14 at 4:30 PM, the Administrator and DON were notified of the IJ and a Plan of Removal was requested at that time. Interview with Administrator on 03/05/14 at 12:15 PM revealed the facility would be getting rid of the van on the advice of the corporate attorneys and the parts previously ordered for the van were returned. He stated the facility would be using a third party

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) company to transport all residents. Interview with Administrator on 03/05/14 at 2:00 PM revealed SW C and Driver D would be watching the training video and then demonstrating how to properly use the straps to secure a wheelchair in the van. He stated he was not aware Driver B strapped in Resident #1's wheelchair incorrectly. Driver B told the Administrator and Investigator after watching the training video it was recommended the straps be placed from the widest point from the wheelchair to the point strap was locked into place and not lock the strap close to the wheelchair and place in the middle of the wheelchair. The facility's training records,dated 03/05/14, reflected SW C and Driver D attended Van Safety and Restraints Training on 03/05/14. The facility's transportation appointment book from 02/19/14 through 03/05/14 reflected resident transportation was arranged with a private transportation company. The facility's Plan of Removal, accepted on 03/05/14, reflected: The following 13 residents, who were also in wheelchairs, could have been affected: Resident #2, Resident #3, Resident #4, Resident #6, Resident #7, Resident #8, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #15, and Resident #18. On 03/05/2014, the Administrator decided to remove the facility van from any future resident transportation services. As such, no further investment would be made to train staff or purchase harness equipment for the van. The facility would keep the existing transportation providers. Driver B was suspended immediately following the incident on 02/19/14, and he returned to work on 02/26/14, but not to drive the van. On 02/24/14, the facility acquired a training video on safe resident transportation which demonstrated proper use and application of wheelchair safety harnesses. Although the training video would no longer be used since the facility van would not be transporting residents, the following employees watched the video on these dates: Driver B (03/03/2014), SW C (03/05/2014), and Driver D (03/05/2014). Observation of SW C on 03/05/14 at 3:40 PM revealed she demonstrated how to properly strap a wheelchair in the van by strapping the wheelchair in at four points. She strapped two in the front and two in the back using the widest points to lock the straps in place. Observation of Driver D on 03/05/14 at 3:50 PM revealed he demonstrated how to properly strap a wheelchair in the van by strapping the wheelchair in at four points, with two in the front and two in the back using the widest points to lock the straps in place. On 03/05/14 the IJ was removed. On 03/05/14 at 4:28 PM, the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility still implementing the Plan of Removal. The facility's Plan of Removal, accepted on 03/05/14, reflected 13 residents, who were in wheelchairs and could have been affected by the facility failures.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to implement written policies and procedures that prohibit neglect of residents for one (Resident #1) of 14 residents reviewed for accidents. 1. Driver B failed to properly secure Resident #1's wheelchair in the van before transporting the resident to [MEDICAL TREATMENT] on 02/19/14. While being transported the straps securing Resident #1's wheelchair in place came loose and Resident #1 fell backwards in his wheelchair against the rear door of the facility van. Driver B removed Resident #1 from the wheelchair and laid him on the floor of the van, and then transported the resident to the local hospital emergency room . Resident #1 sustained a spinal injury causing paralysis to his legs. 2. The facility failed to properly train facility staff on how to secure residents' wheelchair in the van before transporting residents. An Immediate Jeopardy (IJ) was identified on 03/04/14. While the IJ was removed on 03/05/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of pattern because the facility was still implementing the Plan of Removal. These failures could affect the 13 residents in wheelchairs by placing them at risk for injury while being transported in the facility van by Driver B, which could result in resident injuries, falls, other serious mental/physical harm and/or death. Findings included: The facility's current policy, Abuse Prevention and Reporting, revised May 2007 reflected Neglect was defined as Action or inaction that avoids or prevents physical, mental harm, pain, demonstrates disregard or consequences that may constitute a clear and present danger. Resident #1's MDS assessment, dated 02/01/14, reflected the resident was a [AGE] year-old male, who was admitted to the facility on [DATE], and his [DIAGNOSES REDACTED]. He was 65 inches tall and weighed 242 pounds. The MDS assessment further reflected Resident #1 was able to be understood by others, was not cognitively impaired, and walked in his room and walked in the corridor with the assistance of one person. He was able to transfer himself between surfaces with supervision and the assistance of one person. Resident #1 walked with the use of an assistive device and was able to stabilize himself without the assistance of staff. He had no impairment to his lower or upper extremities. Resident #1's Care Plan, printed 03/04/14, reflected he was a fall risk due to abnormality of gait/balance. The Care Plan did not reflect Resident #1's need for transportation to [MEDICAL TREATMENT] appointments. The facility's Provider Investigation Report, dated 02/25/14, reflected, On February 19, 2014, at approx (approximately) 12:30 PM, (Resident #1) was being transported to a doctor's appointment via the Facility van. The van was being driven by (Driver B). Prior to departing the Facility, (Driver B) secured (Resident #1's) wheelchair in the van, and secured (Resident #1) in his wheelchair; (Resident #1) was seated in the wheelchair near the back of the van. (Driver B) stopped the van on the way to the office at the railroad tracks (street names), at an uphill incline. As the van began moving again, (Resident #1) unexpectedly tipped back in the wheelchair which caused his head to come into contact with the back door of the vehicle. (Driver B) estimated that, at the time of the event, the van was moving at less than 5 miles per hour. In response to the above, (Driver B) immediately pulled the van over into the closest parking lot and tended to the Resident. (Resident #1) was noted to be in his wheelchair, which was tipped at approximately a 30-45 degree angle, with his head still against the door. The back of the wheelchair was strapped securely to the van, and the back wheels were locked into place. The strap for the front right wheel of the wheelchair was no longer attached to the floor of the van; the left front strap, while still connected and strapped to the wheelchair, was observed to be loose. It was (Driver B's) recollection that the straps were secure, in place, and free from obvious or observed defect before he left the faciity on [DATE]. (Driver B) assisted (Resident #1) out of the wheelchair, laid him on the floor of the van. Per his observations at the time, there was no sign of bleeding, bruising, skin discoloration or other visible injury. (Driver B) immediately called the Facility and advised the nursing staff of the event; he was instructed to, and did, take (Resident #1) promptly to the Emergency Department at (local hospital) for further evaluation and treatment.However, immediately following the incident, the two front straps were found to be loose or not secure while the back straps remained in place. Upon further assessment of the vehicle when it returned to the Facility, the pin on the locking mechanism of the right front strap was found to have broken off. Additional investigation revealed that the front straps could be released by the application of pressure, whether from a foot or some other mechanism. Interview with Driver B on 03/04/14 at 12:50 PM revealed on 02/19/14 at 11:15 AM, he was taking Resident #1 to an appointment. He stated he loaded the resident in the van, and the resident was facing the front of the van. Driver B revealed Resident #1 was in his wheelchair which was locked and secured in place by the straps. He stated he stopped at the railroad tracks, and when he accelerated, he saw Resident #1 in the rearview mirror flip backwards. Driver B said Resident #1's head was against the back door of the facility van. He stated he pulled the van over and removed the wheelchair and laid Resident #1 flat on the floor of the van and placed a pillow, which was in Resident #1's wheelchair, underneath his head and contacted the facility. Driver B revealed the nurse told him to take Resident #1 to the emergency room because he was only five minutes away from the hospital. He stated he asked the resident what his pain level was and Resident #1 replied his pain level was at 8. Driver B stated he asked Resident #1 questions from the resident's Face Sheet, for example Resident #1's Social Security Number, and the resident was able to recall the information. Driver B revealed once he arrived at the emergency room , a male nurse came to the van with a flat board, and he assisted the nurse in rolling Resident #1 onto the flat board and carrying the resident into the hospital. He revealed now that he had taken the training regarding transporting residents, he knew he could not transport a resident without a foot rest on the wheelchair. Driver B stated Resident #1 did not have a foot rest on his wheelchair because he would propel himself using his legs. Driver B revealed he had worked at the facility for seven years and had never had a resident fall in the van. He stated he had some training when he first started working at the facility and some training every two years. Driver B revealed following the incident he was suspended for one week. Observation of Driver B on 03/04/14 at 12:50 PM revealed he showed the investigator the inside of the van and how the straps were locked into place inside the van with a locking mechanism. There were four straps that connected to the wheelchair to secure it in place. Two straps in the back and two straps in the front. The straps in the back came up from the floor and hooked onto the lower side of the wheelchair. The

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) right front strap connected to the wall of the van and the left front strap connected to the floor of the van. Driver B stated on the left side of the wheelchair, he had to hook the strap to the front of the wheelchair versus the side of the wheelchair where it would be normally be hooked because Resident #1 had padding wrapped on the wheelchair on the left side. Further interview/observation with Driver B on 03/04/14 at 3:00 PM revealed he demonstrated how Resident #1's wheelchair was secured on 02/19/14, the day of the accident. He explained that normally the straps were supposed to be secured wide to the wheelchair, but since Resident #1's wheelchair was wrapped on the bottom left side with padding, the left front strap was secured to the middle of the wheelchair versus the widest part from the wheelchair to the locking mechanism. Driver B explained he had strapped Resident #1 in the van like that before. He demonstrated on the wheelchair how the two back straps securing the wheelchair were placed on the furthest locking device from the wheelchair and then pulled to secure the wheelchair. By pulling the straps from the widest point from the wheelchair, it created tension allowing the wheelchair to be held in place. Driver B secured the right front side of the wheelchair using the strap and securing it to the furthest locking device located on the wall of the van. When securing the left side of the wheelchair, Driver B placed the strap in the middle locking device located in front of the wheelchair and attached the strap to the middle bar of the wheelchair. The strap placed in the middle of the wheelchair was located where the resident would place his/her feet on the floor. Driver B revealed when Resident #1 fell back in the wheelchair, the middle strap had been released and the right front strap popped out of the lock causing only the back two straps of the wheelchair to remain in place. He demonstrated how the wheelchair was placed when the incident occurred. The wheelchair was leaning against the back door of the van almost parallel to the floor of the van with both of the front straps not attached to the wheelchair. Driver B stated he believed Resident #1 dropped his cell phone and while reaching down to pick the phone up off the floor, stepped on the release mechanism on the strap located in the middle of the chair next to his feet. Driver B stated he did not know why the right front strap came unlocked. He revealed he thought that was what happened because Resident #1 said stupid phone when he (Driver B) went to help him. Interview with the DON on 03/04/14 at 3:20 PM revealed Resident #1 wrapped his wheelchair himself because it was hurting his legs. Resident #1's Nursing Progress Note, dated 02/19/14, reflected Driver B said during transport the resident slid from his seat and complained of his back hurting. Driver B reported he was close to the local hospital emergency room and the resident was taken there. Resident #1's Nursing Progress Note, dated 02/19/14, reflected his family member was notified by the nurse that the resident was at the emergency room . Resident #1's family member informed the nurse he/she was already called by the resident, who said his back was hurting. He/She stated he/she was at the emergency room . Resident #1's family member stated he/she was not aware at that time exactly where the spinal problem was, but the resident would have some type of surgery to repair it that day. Resident #1's Nursing Progress Note, dated 02/19/14, the nurse received a call from the emergency room physician requesting information regarding Resident #1. The note reflected, This nurse told him he can transfer from W/C to bed, Bed to W/Chair, and in the bathroom as well with supervision. Dr said 'PT (Resident #1) is saying now he can not move his legs. If he was not walking independently before, does not look anything is wrong. He should be fine to come back. We are still working with him.' Resident #1's hospital Consultation Report, dated 02/19/14, reflected, .CHIEF COMPLAINT: Quadriparesis (muscle weakness affecting all four limbs).Afterwards he had severe neck pain and he was unable to move his arms or legs. He was brought to the (hospital) emergency room where he was found to have severe weakness of his upper extremities.He had no sensation below approximately C6 dermatome (cervical vertebrae in the neck) and severe numbness above that up to C4 (cervical vertebrae in the neck) .IMPRESSION: Central cord syndrome (acute cervical spinal cord injury) and spinal cord compression (occurs when a mass places pressure on anywhere along the cord) due to cervical stenosis (narrowing of the spinal canal in the neck) and head trauma. PLAN: The patient will immediately be transported to the MRI to undergo an MRI of the complete spine.We will take him back for immediate surgical intervention. He will undergo posterior cervical laminectomy with decompression (surgery to remove the lamina which is a thin plate of bone at the back of the neck that makes up the roof of the spine, rods are then implanted to stabilize the neck) of his spinal cord. Afterwards, he will be observed in the intensive care unit. Resident #1's Consultation Report, dated 02/20/14, reflected, .REASON FOR CONSULTATION: ICU management secondary to [MEDICAL CONDITION] status [REDACTED]. The patient postoperatively is still on the vent support in ICU. On 03/05/14 at approximately 9:30 AM the Investigator went to the local hospital. The Investigator was unable to see Resident #1 due to he was still in ICU with a family member at bedside. Interview with DON on 03/04/14 at 9:15 AM revealed Resident #1 was at the local hospital with multiple fractures sustained from the fall in the facility van. The DON stated since the incident occurred, the facility was no longer using the van and training had been conducted. Interview with Administrator on 03/04/14 at 10:35 AM revealed Resident #1 was currently in ICU at the local hospital, and did not know the resident's exact [DIAGNOSES REDACTED]. The Administrator explained the family communicated to the facility Resident #1 did want to return to the facility on ce he was discharged from the hospital. The Administrator's understanding was Resident #1 leaned over in his wheelchair to pick up his cell phone from the floor of the van and when doing so triggered the release with his foot which released the front strap causing the resident's wheelchair to fall backwards. Interview with Resident #1's Family Member 03/04/14 at 10:57 AM revealed the resident broke his spine, had swollen blood vessels in his spine and blood clots in his arm. The Family Member stated Resident #1 was on a ventilator, the vent was taken out of his mouth and placed it in his throat. He/She explained Resident #1 would never be the same person he was before the accident. The Family Member revealed Resident #1 would never be able to use his legs again. He/She felt the facility should take responsibility for the accident. The Family Member stated he/she felt the facility should have done more regarding looking at the procedure for transporting residents. The Provider Response section of the Provider Investigation Report, dated 02/25/14, reflected, .Van suspended from use for Facility transport, or for any other reason Van scheduled to undergo a full and complete inspection by a qualified outside contractor who specializes in transportation safety restraints and systems. Van driver suspended, pending further investigation.Outside transportation service contracted by the Facility for purposes of patient or other transportation pending van inspection and certification. The Provider Action Taken Post-Investigation section of the Provider Investigation Report, dated 02/25/14, reflected, Van taken in for inspection - updated wheelchair straps installed into van, tested by outside company specializing in transportation safety restraints, and deemed safe and appropriate for use. Training video on resident transport and securing resident in vehicle purchased for use in training all staff involved in resident transportation. Training to be done on hire and annually thereafter, and staff required to successfully pass competency developed in connection with resident safety during transport. Staff will not be permitted to work in transporting residents until they have demonstrated aptitude in this area. One-on-one training to be done with (Driver B), followed by administration of competency on resident safety during transport; (Driver B) will not be permitted to return to work until he has successfully demonstrated aptitude in this area.Training provided to facility staff and van drivers regarding procedures and protocol to follow in the event of a resident emergency, especially as related to a transport situation. An interview with the Administrator on 03/04/14 at 1:30 PM revealed the last training reference on the Provider Investigation Report, dated 02/25/14, would be provided by the corporate office, but it had not started yet. He stated they ordered all new parts for the van. Another interview with the Administrator on 03/04/14 at 3:00 PM revealed the facility did not have a facility manual or a manufacturer's manual on how to properly secure a wheelchair in the van using the straps. The facility's training records reflected Driver B attended Van Safety and Restraints training on 03/03/14. The facility's current undated Resident Securement Training materials reflected the front straps should be anchored on the floor track 3 outside front wheels. 30-45 degree angle. Secure close to seat surface to a welded junction. Ensure track fittings and straps are secure. The back straps should be anchored to the inside of the rear wheels. 30-45 degree angle. Secure straps to welded junction of the wheelchair frame. Ensure track fittings and straps are secure. Interview with Human Resources F on 03/04/14 at 2:02 PM revealed there were no training records regarding transportation for Driver B and there was no department of motor vehicle driving record checks. Interview with the Administrator on 03/04/14 at 3:40 PM revealed he was aware there had not been any trainings regarding transporting residents and no checks of staff, who would be transporting residents, driving records. Further interview with the Administrator on 03/04/14 at 11:34 AM revealed the facility was in the process of developing policies and procedures regarding transporting residents. Prior to the incident, the facility did not have policies and procedures in place regarding transporting residents in the facility van. The Administrator stated the facility van had not been used since the incident on 02/19/14, and new parts had been ordered for the van. The Administrator revealed once the parts arrived, the straps in the van would be replaced. Interview with SW C on 03/04/14 at 3:55 PM revealed she arranged all transportation for residents to their appointments. She stated since 02/19/14, the facility had not transported any residents in the facility van. SW C revealed the facility was using a transportation company to transport the residents to appointments. Interview with SW C on 03/04/14 at 10:30 AM revealed the

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CARROLLTON HEALTH AND REHABILITATION CENTER	1618 KIRBY RD CARROLLTON, TX 75006

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

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) last time Driver D drove the van was in January 2014. SW C stated Driver D D did not receive training on transporting residents. Interview with Driver D on 03/05/14 at 10:45 AM revealed he had been working at the facility for five years. He stated he was trained on how to strap resident's wheelchairs in the van and transport residents in the van by Driver B. Driver D revealed the first time he drove the van was three or four years ago. He stated he drove residents in the van in January 2014 when Driver B was on leave. An IJ was identified on 03/04/14. On 03/04/14 at 4:30 PM, the Administrator and DON were notified of the IJ and a Plan of Removal was requested at that time. Interview with Administrator on 03/05/14 at 12:15 PM revealed the facility would be getting rid of the van on the advice of the corporate attorneys and the parts previously ordered for the van were returned. He stated the facility would be using a third party company to transport all residents. Interview with Administrator on 03/05/14 at 2:00 PM revealed SW C and Driver D would be watching the training video and then demonstrating how to properly use the straps to secure a wheelchair in the van. He stated he was not aware Driver B strapped in Resident #1's wheelchair incorrectly. Driver B told the Administrator and Investigator after watching the training video it was recommended the straps be placed from the widest point from the wheelchair to the point strap was locked into place and not lock the strap close to the wheelchair and place in the middle of the wheelchair. The facility's training records,dated 03/05/14, reflected SW C and Driver D attended Van Safety and Restraints Training on 03/05/14. The facility's transportation appointment book from 02/19/14 through 03/05/14 reflected resident transportation was arranged with a private transportation company. The facility's Plan of Removal, accepted on 03/05/14, reflected: The following 13 residents, who were also in wheelchairs, could have been affected: Resident #2, Resident #3, Resident #4, Resident #6, Resident #7, Resident #8, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #15, and Resident #18. On 03/05/2014, the Administrator decided to remove the facility van from any future resident transportation services. As such, no further investment would be made to train staff or purchase harness equipment for the van. The facility would keep the existing transportation providers. Driver B was suspended immediately following the incident on 02/19/14, and he returned to work on 02/26/14, but not to drive the van. On 02/24/14, the facility acquired a training video on safe resident transportation which demonstrated proper use and application of wheelchair safety harnesses. Although the training video would no longer be used since the facility van would not be transporting residents, the following employees watched the video on these dates: Driver B (03/03/2014), SW C (03/05/2014), and Driver D (03/05/2014). Observation of SW C on 03/05/14 at 3:40 PM revealed she demonstrated how to properly strap a wheelchair in the van by strapping the wheelchair in at four points. She strapped two in the front and two in the back using the widest points to lock the straps in place. Observation of Driver D on 03/05/14 at 3:50 PM revealed he demonstrated how to properly strap a wheelchair in the van by strapping the wheelchair in at four points, with two in the front and two in the back using the widest points to lock the straps in place. On 03/05/14 the IJ was removed. On 03/05/14 at 4:28 PM, the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility still implementing the Plan of Removal. The facility's Plan of Removal, accepted on 03/05/14, reflected 13 residents, who were in wheelchairs and could have been affected by the facility failures.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure each resident received assistance devices to prevent accidents for one (Resident #1) of 14 residents reviewed for accidents. 1. Driver B failed to properly secure Resident #1's wheelchair in the van before transporting the resident to dialysis on 02/19/14. While being transported the straps securing Resident #1's wheelchair in place came loose and Resident #1 fell backwards in his wheelchair against the rear door of the facility van. Driver B removed Resident #1 from the wheelchair and laid him on the floor of the van, and then transported the resident to the local hospital emergency room . Resident #1 sustained a spinal injury causing paralysis to his legs. 2. The facility failed to properly train facility staff on how to secure residents' wheelchair in the van before transporting residents. An Immediate Jeopardy (IJ) was identified on 03/04/14. While the IJ was removed on 03/05/14, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy, and a scope of pattern because the facility was still implementing the Plan of Removal. These failures could affect the 13 residents in wheelchairs by placing them at risk for injury while being transported in the facility van by Driver B, which could result in resident injuries, falls, other serious mental/physical harm and/or death. Findings included: Resident #1's MDS assessment, dated 02/01/14, reflected the resident was a [AGE] year-old male, who was admitted to the facility on [DATE], and his [DIAGNOSES REDACTED]. He was 65 inches tall and weighed 242 pounds. The MDS assessment further reflected Resident #1 was able to be understood by others, was not cognitively impaired, and walked in his room and walked in the corridor with the assistance of one person. He was able to transfer himself between surfaces with supervision and the assistance of one person. Resident #1 walked with the use of an assistive device and was able to stabilize himself without the assistance of staff. He had no impairment to his lower or upper extremities. Resident #1's Care Plan, printed 03/04/14, reflected he was a fall risk due to abnormality of gait/balance. The Care Plan did not reflect Resident #1's need for transportation to dialysis appointments. The facility's Provider Investigation Report, dated 02/25/14, reflected, On February 19, 2014, at approx (approximately) 12:30 PM, (Resident #1) was being transported to a doctor's appointment via the Facility van. The van was being driven by (Driver B). Prior to departing the Facility, (Driver B) secured (Resident #1's) wheelchair in the van, and secured (Resident #1) in his wheelchair; (Resident #1) was seated in the wheelchair near the back of the van. (Driver B) stopped the van on the way to the office at the railroad tracks (street names), at an uphill incline. As the van began moving again, (Resident #1) unexpectedly tipped back in the wheelchair which caused his head to come into contact with the back door of the vehicle. (Driver B) estimated that, at the time of the event, the van was moving at less than 5 miles per hour. In response to the above, (Driver B) immediately pulled the van over into the closest parking lot and tended to the Resident. (Resident #1) was noted to be in his wheelchair, which was tipped at approximately a 30-45 degree angle, with his head still against the door. The back of the wheelchair was strapped securely to the van, and the back wheels were locked into place. The strap for the front right wheel of the wheelchair was no longer attached to the floor of the van; the left front strap, while still connected and strapped to the wheelchair, was observed to be loose. It was (Driver B's) recollection that the straps were secure, in place, and free from obvious or observed defect before he left the faciity on [DATE]. (Driver B) assisted (Resident #1) out of the wheelchair, laid him on the floor of the van. Per his observations at the time, there was no sign of bleeding, bruising, skin discoloration or other visible injury. (Driver B) immediately called the Facility and advised the nursing staff of the event; he was instructed to, and did, take (Resident #1) promptly to the Emergency Department at (local hospital) for further evaluation and treatment.However, immediately following the incident, the two front straps were found to be loose or not secure while the back straps remained in place. Upon further assessment of the vehicle when it returned to the Facility, the pin on the locking mechanism of the right front strap was found to have broken off. Additional investigation revealed that the front straps could be released by the application of pressure, whether from a foot or some other mechanism. Interview with Driver B on 03/04/14 at 12:50 PM revealed on 02/19/14 at 11:15 AM, he was taking Resident #1 to an appointment. He stated he loaded the resident in the van, and the resident was facing the front of the van. Driver B revealed Resident #1 was in his wheelchair which was locked and secured in place by the straps. He stated he stopped at the railroad tracks, and when he accelerated, he saw Resident #1 in the rearview mirror flip backwards. Driver B said Resident #1's head was against the back door of the facility van. He stated he pulled the van over and removed the wheelchair and laid Resident #1 flat on the floor of the van and placed a pillow, which was in Resident #1's wheelchair, underneath his head and contacted the facility. Driver B revealed the nurse told him to take Resident #1 to the emergency room because he was only five minutes away from the hospital. He stated he asked the resident what his pain level was and Resident #1 replied his pain level was at 8. Driver B stated he asked Resident #1 questions from the resident's Face Sheet, for example Resident #1's Social Security Number, and the resident was able to recall the information. Driver B revealed once he arrived at the emergency room , a male nurse came to the van with a flat board, and he assisted the nurse in rolling Resident #1 onto the flat board and carrying the resident into the hospital. He revealed now that he had taken the training regarding transporting residents, he knew he could not transport a resident without a foot rest on the wheelchair. Driver B stated Resident #1 did not have a foot rest on his wheelchair because he would propel himself using his legs. Driver B revealed he had worked at

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) the facility for seven years and had never had a resident fall in the van. He stated he had some training when he first started working at the facility and some training every two years. Driver B revealed following the incident he was suspended for one week. Observation of Driver B on 03/04/14 at 12:50 PM revealed he showed the investigator the inside of the van and how the straps were locked into place inside the van with a locking mechanism. There were four straps that connected to the wheelchair to secure it in place. Two straps in the back and two straps in the front. The straps in the back came up from the floor and hooked onto the lower side of the wheelchair. The right front strap connected to the wall of the van and the left front strap connected to the floor of the van. Driver B stated on the left side of the wheelchair, he had to hook the strap to the front of the wheelchair versus the side of the wheelchair where it would be normally be hooked because Resident #1 had padding wrapped on the wheelchair on the left side. Further interview/observation with Driver B on 03/04/14 at 3:00 PM revealed he demonstrated how Resident #1's wheelchair was secured on 02/19/14, the day of the accident. He explained that normally the straps were supposed to be secured wide to the wheelchair, but since Resident #1's wheelchair was wrapped on the bottom left side with padding, the left front strap was secured to the middle of the wheelchair versus the widest part from the wheelchair to the locking mechanism. Driver B explained he had strapped Resident #1 in the van like that before. He demonstrated on the wheelchair how the two back straps securing the wheelchair were placed on the furthest locking device from the wheelchair and then pulled to secure the wheelchair. By pulling the straps from the widest point from the wheelchair, it created tension allowing the wheelchair to be held in place. Driver B secured the right front side of the wheelchair using the strap and securing it to the furthest locking device located on the wall of the van. When securing the left side of the wheelchair, Driver B placed the strap in the middle locking device located in front of the wheelchair and attached the strap to the middle bar of the wheelchair. The strap placed in the middle of the wheelchair was located where the resident would place his/her feet on the floor. Driver B revealed when Resident #1 fell back in the wheelchair, the middle strap had been released and the right front strap popped out of the lock causing only the back two straps of the wheelchair to remain in place. He demonstrated how the wheelchair was placed when the incident occurred. The wheelchair was leaning against the back door of the van almost parallel to the floor of the van with both of the front straps not attached to the wheelchair. Driver B stated he believed Resident #1 dropped his cell phone and while reaching down to pick the phone up off the floor, stepped on the release mechanism on the strap located in the middle of the chair next to his feet. Driver B stated he did not know why the right front strap came unlocked. He revealed he thought that was what happened because Resident #1 said stupid phone when he (Driver B) went to help him. Interview with the DON on 03/04/14 at 3:20 PM revealed Resident #1 wrapped his wheelchair himself because it was hurting his legs. Resident #1's Nursing Progress Note, dated 02/19/14, reflected Driver B said during transport the resident slid from his seat and complained of his back hurting. Driver B reported he was close to the local hospital emergency room and the resident was taken there. 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Further interview with the Administrator on 03/04/14 at 11:34 AM revealed the facility was in the process of developing policies and procedures regarding transporting residents. Prior to the incident, the facility did not have

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) policies and procedures in place regarding transporting residents in the facility van. The Administrator stated the facility van had not been used since the incident on 02/19/14, and new parts had been ordered for the van. The Administrator revealed once the parts arrived, the straps in the van would be replaced. Interview with SW C on 03/04/14 at 3:55 PM revealed she arranged all transportation for residents to their appointments. She stated since 02/19/14, the facility had not transported any residents in the facility van. SW C revealed the facility was using a transportation company to transport the residents to appointments. Interview with SW C on 03/04/14 at 10:30 AM revealed the last time Driver D drove the van was in January 2014. SW C stated Driver D D did not receive training on transporting residents. Interview with Driver D on 03/05/14 at 10:45 AM revealed he had been working at the facility for five years. He stated he was trained on how to strap resident's wheelchairs in the van and transport residents in the van by Driver B. Driver D revealed the first time he drove the van was three or four years ago. He stated he drove residents in the van in January 2014 when Driver B was on leave. An IJ was identified on 03/04/14. On 03/04/14 at 4:30 PM, the Administrator and DON were notified of the IJ and a Plan of Removal was requested at that time. Interview with Administrator on 03/05/14 at 12:15 PM revealed the facility would be getting rid of the van on the advice of the corporate attorneys and the parts previously ordered for the van were returned. He stated the facility would be using a third party company to transport all residents. Interview with Administrator on 03/05/14 at 2:00 PM revealed SW C and Driver D would be watching the training video and then demonstrating how to properly use the straps to secure a wheelchair in the van. He stated he was not aware Driver B strapped in Resident #1's wheelchair incorrectly. Driver B told the Administrator and Investigator after watching the training video it was recommended the straps be placed from the widest point from the wheelchair to the point strap was locked into place and not lock the strap close to the wheelchair and place in the middle of the wheelchair. The facility's training records,dated 03/05/14, reflected SW C and Driver D attended Van Safety and Restraints Training on 03/05/14. The facility's transportation appointment book from 02/19/14 through 03/05/14 reflected resident transportation was arranged with a private transportation company. The facility's Plan of Removal, accepted on 03/05/14, reflected: The following 13 residents, who were also in wheelchairs, could have been affected: Resident #2, Resident #3, Resident #4, Resident #6, Resident #7, Resident #8, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #15, and Resident #18. On 03/05/2014, the Administrator decided to remove the facility van from any future resident transportation services. As such, no further investment would be made to train staff or purchase harness equipment for the van. The facility would keep the existing transportation providers. Driver B was suspended immediately following the incident on 02/19/14, and he returned to work on 02/26/14, but not to drive the van. On 02/24/14, the facility acquired a training video on safe resident transportation which demonstrated proper use and application of wheelchair safety harnesses. Although the training video would no longer be used since the facility van would not be transporting residents, the following employees watched the video on these dates: Driver B (03/03/2014), SW C (03/05/2014), and Driver D (03/05/2014). Observation of SW C on 03/05/14 at 3:40 PM revealed she demonstrated how to properly strap a wheelchair in the van by strapping the wheelchair in at four points. She strapped two in the front and two in the back using the widest points to lock the straps in place. Observation of Driver D on 03/05/14 at 3:50 PM revealed he demonstrated how to properly strap a wheelchair in the van by strapping the wheelchair in at four points, with two in the front and two in the back using the widest points to lock the straps in place. On 03/05/14 the IJ was removed. On 03/05/14 at 4:28 PM, the Administrator and DON were notified the IJ was removed. While the IJ was removed, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility still implementing the Plan of Removal. The facility's Plan of Removal, accepted on 03/05/14, reflected 13 residents, who were in wheelchairs and could have been affected by the facility failures.