

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2023
NAME OF PROVIDER OR SUPPLIER Burns Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Monroe Street NW Russellville, AL 35653	

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)
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, Resident Identifier (RI) #103's medical record review, and a facility policy titled Care Plan, Comprehensive, the facility failed to ensure Employee Identifier (EI) #7 Certified Nursing Assistant (CNA), followed RI #103's care plan intervention to have two persons assistance for transfer of RI #103 using a mechanical (Hoyer) lift.</p> <p>On 01/06/2023 EI #7, attempted to transfer RI #103, using a mechanical lift, by herself and without the assistance of another staff member. EI #7 stated she observed RI #103 slipping out of the Hoyer lift sling pad. EI #7 stated she attempted to lower the resident, but the resident fell from the mechanical lift, hitting his/her head on the floor. As a result of the fall, RI #103 sustained a laceration to his/her scalp and a hematoma that required being sent to the emergency room for treatment. The laceration to RI #103's scalp required 20 sutures to close the skin. A Computerized Tomography scan (x-ray images) confirmed RI #103 suffered a fracture of his/her C2 vertebra (second vertebra of the cervical spine or neck).</p> <p>This deficient practice placed RI #103, one of three residents sampled for requiring a mechanical lift for transferring, in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment or death.</p> <p>On 03/02/2023 at 10:36 AM, the Administrator, EI #1; the Director of Nursing, EI #2; and the facility's President, EI #12; were provided a copy of the immediate jeopardy template and notified of the findings at the immediate jeopardy level in the area of Comprehensive Resident Centered Care Plan, at F656-Develop/Implement Comprehensive Care Plan. The immediate jeopardy began on 01/06/2023 and continued until 01/13/2023, when the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, immediate jeopardy past noncompliance was cited. Total census 50.</p> <p>Findings Include:</p> <p>A facility policy titled, Care Plan, Comprehensive, implemented 09/2016 and last reviewed/revised 01/2023 documented:</p> <p>Purpose: . The facility develops a comprehensive plan of care for each resident . to meet a resident's medical, nursing, and mental/psychosocial needs that are identified in the comprehensive assessment. The care plans will describe the following: 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 015009
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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Policy: .3 . f. Resident specific interventions that reflect the resident's needs and preferences .</p> <p>RI #103 was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's Disease and Macular Degeneration.</p> <p>RI #103's annual Minimal Data Set (MDS), with an Assessment Reference Date of 11/07/2022 assessed RI #103 as a two person assist with transfers.</p> <p>RI #103's care plan for being at high risk for falls related to impaired balance and total dependence on two staff and mechanical lift for transfer staff was initiated on 08/22/2017 and revised on 10/14/2019.</p> <p>RI #103's care plan for an Activity of Daily Living (ADL) self care performance deficit related to weakness, Alzheimer's Dementia, Arthritis and Macular Degeneration was initiated on 08/22/2017 and revised on 05/10/2018 and documented an intervention as follows: . TRANSFER: The resident requires total assistance by 2 (two) staff to move between surfaces with use of Hoyer lift.</p> <p>RI #103's Incident Report dated 01/06/2023, prepared by EI #2, Registered Nurse (RN), Director of Nursing Services (DON), documented . Resident being transferred per (by) mechanical lift from shower bed . CNA verbalized resident began to slip out of lift pad. Attempted to assist. Resident fell to the floor and hit head. Immediate assessment completed. Laceration to the scalp measuring 4 cm (centimeter) x 4.5 cm noted. Hematoma noted at laceration site measures 9 x 6 cm. Moderate blood loss noted. EMS (Emergency Medical Services) contacted for transport to (name of hospital) for evaluation.</p> <p>RI #103's Emergency Department Record documented: . Details of the fall: The patient fell from an upright position. Onset: The symptoms/episode began/occurred acutely. Associate injuries: The patient sustained injury to the head, laceration, neck injury . Laceration . Wound repair of 4 cm . subcutaneous laceration to scalp. Skin closed with 20 . sutures.</p> <p>RI #103's hospital Radiology Report Details documented: Patient Name: RI #103's name . Procedure Date: 1/6/2023 . EXAM: CT (Computerized Tomography) Cervical Spine without contrast . IMPRESSION: Nondisplaced fracture through the posterior lamina of C2 with likely extension into the left C2-3 left facet .</p> <p>RI #103's hospital Discharge Summary Report documented: . Date of admission: [DATE] . Patient . who was admitted . after a fall at the nursing home. During that fall, (he/she) suffered a scalp laceration and then x-ray confirmed C2 fracture. During . hospital stay, . (RI #103) has been fitted for a cervical collar. DISCHARGE DIAGNOSES: Include head laceration, nondisplaced fracture of C2 (cervical), .</p> <p>On 02/10/2023 at 9:13 AM, an interview was conducted with EI #7, CNA. EI #7 was asked what happened on 01/06/2023 when she transferred RI #103. EI #7 said during transfer from the shower bed, she lifted RI #103 up in the lift and noticed RI #103 was sliding to the right side and was not in the sling properly. EI #7 stated she attempted to grab the lift and RI #103 fell to the floor. When asked how many staff were required to transfer RI #103 with a mechanical lift according to the care plan, EI #7 said, there was supposed to be two people, but it was just her. She further stated, she knew better, and RI #103's care plan documented that two people were required to assist with transfer. EI #7 said she did not follow the care plan since she transferred the resident by herself and stated if there had been two people transferring RI #103, there would have been two people to watch RI #103 to</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>make sure she/he was in the sling properly and it was a safe transfer. EI #7 further said, RI #103 sustained a laceration and was told he/she may have a C2 fracture. EI #7 said the care plan was to be followed to avoid situations such as falling and having an injury, such as the case with RI #103. EI #7 confirmed this fall could have been avoided if two people assisted with the lift.</p> <p>On 02/09/2023 at 12:30 PM, an interview was conducted with EI #8, Registered Nurse (RN). EI #8 reported she went to RI #103's room after the fall on 01/06/2023. EI #8 said EI #2 (DON/RN) assessed RI #103, who had a laceration to the back of his/her head. EI #8 was asked how did RI #103 fall. EI #8 said RI #103 fell from the lift from what she could see. EI #8 said RI #103 was care planned for a two person assist with a Hoyer lift.</p> <p>On 02/09/2023 at approximately 4:15 PM, an interview was conducted with EI #2, DON regarding the incident involving RI #103 on 01/06/2023. EI #2 said she was notified by a staff member that they needed assistance on the hall. When she arrived, she observed RI #103 on the floor with the mechanical lift in front of RI #103. EI #2 further said she noticed the sling was attached to the lift. EI #2 said she observed blood on the floor, and she immediately assessed RI #103's head and found a laceration to the scalp and a hematoma. EI #2 said, EI #7 told her she did not have anyone assisting her with the transfer of RI #103 with the mechanical lift. EI #2 said, two persons were required for mechanical lift transfers. EI #2 stated, RI #103 was also care planned for a two person assist for transfer and that EI #7 did not follow the care plan policy.</p> <p>A follow up interview conducted with EI #2 DON on 02/10/2023 at 4:35 PM. EI #2 said, EI #7 did not follow RI #103's care plan. EI #2 stated, RI #103 has always been a two person assist with transfer. EI #2 further stated the care plan should be followed to ensure accurate and safe care was provided to the resident.</p> <p>On 02/10/2023 at 4:05 PM, an interview was conducted with EI #10, RN/Care Plan Coordinator. EI #10 said the purpose of the care plan was to have a plan of care for the residents so all staff could follow the plan of care. EI #10 said RI #103 required a mechanical lift and two person assist for transfer. EI #10 was asked if EI #7 followed the plan of care for RI #103 when she transferred RI #103 by herself. EI #10 said, no. When asked if EI #7 should have followed the care plan for RI #103, EI #10 said, yes.</p> <p>On 02/10/2023 at 4:15 PM, an interview was conducted with EI #1, Administrator. EI #1 was asked what the facility determined about how RI #103 fell. EI #1 said the facility determined EI #7 transferred the resident by herself and RI #103 fell from the sling. EI #1 continued to say that it was his understanding RI #103 fell away from the lift and if someone had been on the other side, RI #103 would not have fallen. EI #1 said, a lift was required for RI #103's transfer and RI #103 was care planned for two person assist with transfer. EI #1 was asked if EI #7 followed RI #103's care plan. EI #1 said EI #7 did not follow the care plan, but she should have. EI #1 was asked what was the purpose of the care plan. EI #1 said for staff to know how to care for the resident.</p> <p>On 03/01/2023 at 2:00 PM an interview was conducted with EI #11, RI #103's attending Medical Doctor. EI #11 was asked what did non-displaced fracture through posterior lamina mean. EI #11 replied, the posterior lamina was at the back of the neck along the outer ring of the vertebrae. EI #11 was asked what risks were associated with a C2 or C3 fracture. EI #11 replied, if the fracture displaced, it could potentially cause paralysis but with a non-displaced fracture it would be limited to limited range of motion until healed. EI #11 was asked if RI #103's injuries were serious. EI #11 replied that anytime a resident had a neck fracture that it was considered serious.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This deficient practice was cited as a result of the investigation of complaint/report number AL00042944.</p> <p>*****</p> <p>The facility took immediate action to correct the noncompliance by:</p> <ol style="list-style-type: none"> 1. Reported the incident to Alabama Department of Public Health (ADPH) 01/09/2023 and conducted an investigation. 2. Completed in-service with staff on following care guides with transfer using the mechanical lift. Completed 01/09/2023. 3. The Care Plan Coordinator and designee reviewed the care plan for each resident who required the use of a mechanical lift to ensure resident specific interventions were present. Completed 01/09/2023. 4. DON completed assessment for proper sling fit for each resident who used a mechanical lift, and this information was added to resident care plan, Plan Of Care (POC) task list, and color coded paper identifier on closet door for any resident care planned for mechanical lift. Care Plan will be update by the MDS Coordinator/Care Plan Coordinator, with weight loss/gain, as well as any assessments. Completed 01/09/2023. 5. Quality Assurance (QA) meeting held on 01/07/2023 to create plan of correction (POC). 6. QA/Root cause analysis (RCA) meeting held on 01/13/2023. 7. Monitoring for two-person assist compliance . The Director of Nursing (DON), Administrator, or designee, will monitor through direct observation mechanical lift transfers during rounds that will occur using mechanical lift audit tool. Weekly for 4 weeks and then; monthly for 6 months and then; quarterly. Start date 01/07/2023 - Ongoing. <p>After review and verification of the information provided in the facility's corrective action plan, inservice/education records, monitoring tools and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 01/6/2023 through 01/13/2023 with ongoing monitoring implemented; thus, immediate jeopardy past noncompliance was cited.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice was cited as a result of the investigation of complaint/report number AL00042944.</p> <p>*****</p> <p>The facility took immediate action to correct the noncompliance by:</p> <ol style="list-style-type: none"> 1. Reported the incident to Alabama Department of Public Health (ADPH) 1/9/2023 and conducted an investigation. 2. Completed in-service with staff on following care guides with transfer using the mechanical lift, facility lift procedures with return demonstration. Completed 1/9/23. 3. The Care Plan Coordinator and designee reviewed the care plan for each resident who required the use of a mechanical lift to ensure resident specific interventions were present. Completed 1/9/23. 4. DON completed assessment for proper sling fit for each resident who used a mechanical lift and this information was added to resident care plan, Plan Of Care (POC) task list, and color coded paper identifier on closet door for any resident care planned for mechanical lift. Care Plan will be update by the MDS Coordinator/Care Plan Coordinator, with weight loss/gain, as well as any assessments. Completed 1/9/23. 5. Quality Assurance (QA) meeting held on 1/7/2023 to create plan of correction (POC). 6. QA/Root cause analysis (RCA) meeting held on 1/13/2023. 7. Monitoring for two-person assist compliance . The Director of Nursing (DON), Administrator, or designee, will monitor through direct observation mechanical lift transfers during rounds that will occur using mechanical lift audit tool. Weekly for 4 weeks and then; monthly for 6 months and then; quarterly. Start date 1/7/23 - Ongoing. <p>After review and verification of the information provided in the facility's corrective action plan, inservice/education records, monitoring tools and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 01/6/2023 through 01/13/2023 with ongoing monitoring implemented; thus, immediate jeopardy past noncompliance was cited.</p> <p>Based on interviews, review of Resident Identifier (RI) 103's medical record, RI #103's hospital medical records, the Resident Incident Report, the facility Investigative Summary, a facility policy titled Safe Resident Handling/Transfer, the Arjo Sling/Size Guide, and a report submitted by the facility to the Alabama Department of Public Health Online Incident Reporting System, the facility failed to ensure Employee Identifier (EI) #7 Certified Nursing Assistant (CNA) followed the facility policy for Safe Resident Handling/Transfer when EI #7 transferred RI #103 on 01/06/2023.</p> <p>On 01/06/2023, EI #7 CNA attempted to transfer RI #103 using the mechanical lift (Hoyer lift) by herself and without obtaining assistance from other staff; and further, EI #7 failed to utilize the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>appropriate size sling to according to the RI #103's weight during transfer using the mechanical lift. EI #7 stated she observed RI #103 slipping from the mechanical lift sling, resulting in RI #103 falling from the lift and hitting his/her head on the floor. RI #103 sustained a laceration to the scalp, with a hematoma (blood collected or pooled under the skin). RI #103 was transported to the local hospital for evaluation. While at the hospital, RI #103 was found to have a laceration to the scalp that required 20 sutures to close the wound. A Computerized Tomography scan (x-ray images) confirmed RI #103 suffered a fracture of the C2 vertebra (second vertebra of the cervical spine or neck).</p> <p>This deficient practice placed RI #103, one of three residents sampled who required the use of a mechanical lift for transfers, in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment or death.</p> <p>On 03/02/2023 at 10:36 AM, the Administrator, EI #1; the Director of Nursing, EI #2; and the facility's President, EI #12; were provided a copy of the immediate jeopardy templates and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Quality of Care, at F689-Free of Accident Hazards/Supervision/Devices. The immediate jeopardy began on 01/06/2023 and continued until 01/13/2023, when the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, immediate jeopardy past noncompliance was cited. Total census 50.</p> <p>Findings Include:</p> <p>On 01/09/2023 the facility submitted an initial report to the State Survey Agency via the Alabama Department of Public Health Online Incident Reporting System. This report indicated RI #103 was transferred by mechanical lift and fell from the lift to the floor and had to be transferred to the hospital by Emergency Medical Services (EMS) and had a laceration to the scalp.</p> <p>A facility policy titled, Safe Resident Handling/Transfers, revised 11/2022 documented: . Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident . Compliance Guidelines: . 8. The facility will ensure . appropriate . sizes of slings to accommodate residents . on proper sling sizing. 10. Two staff members must be utilized when transferring residents with a mechanical lift.</p> <p>RI #103 was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's Disease and Macular Degeneration.</p> <p>Review of RI #103's annual Minimal Data Set (MDS) assessment with an Assessment Reference Date of 11/07/2022 revealed RI #103 was coded as a two person assist for transfer.</p> <p>RI #103's Incident Report dated 01/06/2023, prepared by EI #2, Registered Nurse (RN)/DON, documented . Resident being transferred per (by) mechanical lift from shower bed . CNA verbalized resident began to slip out of lift pad. Resident fell to the floor and hit head. Immediate assessment completed. Laceration to the scalp measuring 4 cm (centimeter) x 4.5 cm noted. Hematoma noted at laceration site measures 9 x 6 cm. Moderate blood loss noted. EMS contacted for transport to (name of hospital) for evaluation.</p> <p>A handwritten statement dated 01/06/2023, signed by EI #7 CNA documented: Was transferring (transferring) resident from the shower bed to (his/her) bed with the Hoyer lift. I started to turn the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>resident, and as I started to move (him/her) (he/she) started sliding out of the sling and then went backwards and hit (his/her) [NAME] (head). The nurse on the hall immediately came to address the situation .</p> <p>A handwritten statement dated 01/06/2023, signed by EI #8 RN documented: I was coming around the corner at nurses desk, when I heard a staff yelling, we need a nurse. resident . was laying on the floor, (his/her) left leg still in the sling. With CNA next to (his/her) and another staff member. As I got to resident I noticed blood under (his/her) head. I grabbed gloves and yelled for another nurse to come help me. Then I told the other nurse to get the DON. DON came running down the hall to assist me (with) the resident. I secured the residents head. DON provided wound care to laceration, dressing applied. EMS called.</p> <p>RI #103's Emergency Department Record documented: . Details of the fall: The patient fell from an upright position. Onset: The symptoms/episode began/occurred acutely. Associate injuries: The patient sustained injury to the head, laceration, neck injury . Laceration . Wound repair of 4 cm . subcutaneous laceration to scalp. Skin closed with 20 . sutures.</p> <p>RI #103's hospital Radiology Report Details documented: Patient Name: (RI #103's name) . Procedure Date: 1/6/2023 . EXAM: CT (Computerized Tomography) Cervical Spine without contrast . IMPRESSION: Nondisplaced fracture through the posterior lamina of C2 with likely extension into the left C2-3 left facet .</p> <p>RI #103's Discharge Summary Report documented: Date of admission: [DATE] . Patient . who was admitted . after a fall at the nursing home . During that fall, (he/she) suffered a scalp laceration and then x-ray confirmed C2 fracture. During . hospital stay . has been fitted for a cervical collar . DISCHARGE DIAGNOSES: Include head laceration, nondisplaced fracture of C2 (cervical), .</p> <p>The facility Investigation Summary dated 01/09/2023 documented the following regarding EI #7 CNA: . due to the extent of the noncompliance with proper policy and procedure with result in physical injury to the resident, termination of employment would be effective immediately. Therefore, termination/resignation of employment effective 1/9/23.</p> <p>On 02/10/2023 at 9:13 AM, a phone interview was conducted with EI #7, CNA. EI #7 was asked what happened on 01/06/2023 when she transferred RI #103. EI #7 said during the transfer from the shower bed, she lifted RI #103 up in the lift and noticed she/he was sliding to the right side and was not in the sling properly. EI #7 said she attempted to grab the lift, but RI #103 fell to the floor. When asked about training on the proper use of the mechanical lift and the appropriate sling size for residents, EI #7 said, she had been trained but did not remember when. EI #7 said, determination of the sling size to use was made by the resident's weight and the slings were color coded by size and weight. When asked what RI #103's weight was, EI #7 did not know. However, EI #7 said, RI #103 was a large person, so she used a large sling which was a blue color. When asked what RI #103's care plan documented about transfer with a mechanical lift, EI #7 said, RI #103 was a two person assist for transfer. EI #7 said, if she had followed RI #103's care plan for two people transferring RI #103 with the mechanical lift, there would have been two people watching RI #103 to ensure RI #103 was in the sling properly for a safe transfer. EI #7 said, she was disciplined about not following procedures and policies for transfer of residents using the lift. EI #7 said, the accident with RI #103 could have been avoided if she had done the right thing, and two people had assisted RI #103 in the lift transfer. EI #7 said, now she understood the consequences of not following the policy.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/09/2023 at 12:30 PM, an interview was conducted with EI #8 RN. EI #8 said, she heard someone say they needed a nurse. EI #8 stated, when she got on the hall, she observed RI #103 on the floor and RI #7 was by RI #103's side. EI #8 stated, she observed blood on the floor. When asked how RI #103 came to be on the floor, EI #8 said, she assumed RI #103 fell from the lift. EI #8 stated that RI #103 required a mechanical lift for transfers and the facility's policy was to use a two person assist with a mechanical lift. EI #8 said, the DON came to assess RI #103, treated the laceration on RI #103's head, EMS was called, and they stayed with RI #103 until EMS arrived.</p> <p>On 02/09/2023 at approximately 4:15 PM, an interview was conducted with EI #2, RN/ DON. EI #2 was asked what happened regarding the incident with RI #103 on 01/06/2023. EI #2 said she was notified by a staff member and when she arrived at RI #103's room she observed RI #103 on the floor and the mechanical lift in front of RI #103. EI #2 stated she noticed the sling was attached to the lift, blood was on the floor, and upon assessment of RI #103's head, she found a laceration to the scalp and a hematoma. EI #2 said, EI #7 had reported she was transferring RI #103 from the shower bed to bed when RI #103 began sliding to the right, and before EI #7 could help RI #103, RI #103 came out of the head position of the sling and fell on the floor. EI #2 was asked how many staff assisted with the transfer. EI #2 said, EI #7 told her she did not have anyone assisting with the lift at the time of RI #103's transfer. EI #2 said, EI #7 should have had another person to assist her with transfer of RI #103, as it had always been the policy of the facility to require two person assistance for transfer of residents by mechanical lift. EI #2 said, RI #103 was also care planned for a two person assist for transfers. EI #2 stated, EI #7 did not use the correct size sling during the transfer of RI #103. EI #2 stated, EI #7 used the blue sling and the appropriate sling color for RI #103 was yellow.</p> <p>RI #103's Weights and Vitals Summary documented, RI #103's weight was 145 pounds on 01/02/2023.</p> <p>An ARJO SLING/SIZE GUIDE documented a medium size sling with a yellow color code was the appropriate sling size for RI #103's weight range of 121-165 pounds. The extra large (XL) with a blue color code was recommended for adults who weighed 308-440 pounds.</p> <p>On 02/28/2023 at 2:50 PM, a follow-up interview was conducted with EI #2 DON. EI #2 was asked what the facility's process was for selecting the proper sling size at the time of RI #103's fall. EI #2 reported, at that time, residents who required mechanical lifts were weighed at least monthly, staff performing the transfer would check the resident's documented weight and follow the manufacturer's guidelines.</p> <p>On 2/10/2023 at 4:15 PM, the Administrator, EI #1 was interviewed regarding the incident involving RI #103 falling on 01/06/2023. EI #1 stated the fall could have been avoided if there had been two people assisting with the transfer. EI #1 stated it has always been the policy of the facility to make sure residents were transferred by mechanical lift safely with two persons. EI #1 stated, EI #7 did not follow the facility's policy when transferring RI #103 with the mechanical lift.</p> <p>On 03/01/2023 at 2:00 PM an interview was conducted with EI #11, RI #103's attending Medical Doctor. EI #11 was asked what did non-displaced fracture through posterior lamina mean. EI #11 replied, the posterior lamina was at the back of the neck along the outer ring of the vertebrae. EI #11 was asked what risks were associated with a C2 or C3 fracture. EI #11 replied, if the fracture displaced, it could potentially cause paralysis but with a non-displaced fracture it would be limited to limited range of motion until healed. EI #11 was asked if RI #103's injuries were serious. EI #11 replied that anytime a resident had a neck fracture that it was considered serious.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2023
NAME OF PROVIDER OR SUPPLIER Burns Nursing Home, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Monroe Street NW Russellville, AL 35653	
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)		
<p>F 0851</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on record review, interview, and Payroll Based Journal (PBJ) Report, the facility failed to report staffing data from July 01, 2022 - September 30, 2022, to Centers for Medicare & Medicaid Services (CMS).</p> <p>This affected one quarter of data reviewed during the survey.</p> <p>Findings Include:</p> <p>The PBJ report generated for the quarter of 07/01/2022 through 09/30/2022 documented:</p> <p>. This Staffing Data Report identifies areas of concern that will be triggered .</p> <p>Metric</p> <p>Failed to Submit Data for the Quarter . Triggered = No Data Submitted for Quarter .</p> <p>On 02/09/2023 at 2:46 PM, an interview was conducted with Employee Identifier (EI) #1, Administrator. EI #1 stated he was responsible for turning in PBJ data to CMS. EI #1 was asked why the PBJ data was not reported to CMS from 07/01/2022 through 09/30/2022. EI #1 explained the data was not turned in monthly due to a computer issue, that was only recently resolved. EI #1 explained he planned to manually enter the data into the [NAME] system prior to the due date on 11/14/2022 but was unable to meet the deadline. EI #1 stated it was important to report the data because it was used for the facility's star rating and reimbursement rate.</p>		