STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savannah Heights	601 S Prairie Street Mount Pleasant, IA 52641

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on staff interviews, record review, and the facility policy, the facility failed to complete the neuro assessments after an unwitnessed fall for 1 of 3 residents reviewed for assessment and intervention (Resident #1). The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #1 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS revealed resident dependent with toileting hygiene, and partial/moderate assistance with bed to chair transfer. The MDS revealed diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, mood disturbance, and anxiety. The MDS revealed the resident took opioids and used bed and chair alarms daily. The Care Plan revealed a focus area dated 1/10/24 that the resident had moderate risk for falls related to unaware of safety needs. The interventions dated 3/25/24 revealed fall intervention for a fall on 3/23/24 the resident will have physical therapy/occupational therapy evaluation and treat. The Physician Orders revealed the following medication orders: a. Tramadol HCL oral tablet 50 mg - Give 0.5 mg tablet by mouth three times a day for pain, give with Tylenol 500 mg at 7 AM/1 PM/6 PM - ordered on 10/6/23 and discontinued on 3/27/24 b. per [name redacted] on call provider- send the resident to emergency room (ER) for evaluation of pain with transfers following fall yesterday- start date 3/24/23 c. Tramadol HCL oral tablet 50 mg- give 1 tablet by mouth every 6 hours for pain- ordered on 3/26/24 with start date of 3/27/24 d. Calcitonin nasal solution - 1 spray alternating nostrils one time a day for pain alternate nostrils with each dose- ordered on 3/26/24 with start date of 3/27/24 The Progress Note dated 3/23/24 at 4:20 PM (late entry-documented on 3/24/24 at 12:18 PM) revealed the following information: a. Fall Details: Date/Time of fall: 3/23/24 at 4:20 PM: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Fall not witnessed. The fall occurred in the resident's room. c. Activity at the time of fall: Resident moved self from piano bar into room without staff assistance and attempted to toilet self. d. Reason for the fall was evident. e. Did an injury occur as a result of the fall: No. f. Did fall result in an ER (emergency room) visit/hospitalization : No. g. Provider: [name redacted] Time notified: 03/23/2024 h. Notified of Fall: Fall Details Note:Resident previously been in piano bar watching peers play cards. She proceeded to wheel self to room, closed door and attempted to transfer self to toilet. CNA (Certified Nurse Aide) [name redacted] found resident on floor with alarm sounding, sat in the middle of the room upright. This nurse called to room and resident laughed, sat upright in the middle of the floor. When asked what happened resident laughed and said I was hanging onto the bed, then I was on my butt. i. Contributing Factors: 1. Recent change in environment: No. 2. Was fluid spilled on floor: No. 3. Clutter present on the floor: No. 4. Floor mat was on floor: No. 5. Poor lighting in the area: No. 6. Bed was at an improper height: No. 7. Other furniture involved: Yes. Wheelchair was involved in the fall. Wheelchair unlocked at time of fall. Wheelchair footrest(s) were not in the way at the time of fall. 8. Wearing glasses at the time of the fall: Yes. 9. Footwear at time of fall: Shoes. Resident didn't use cane/walker as instructed. Resident used incontinence supplies at the time of the fall. 10. Incontinent at time of fall: No. 11. Bedside call light on when resident found: No. 12. Bathroom call light on when resident was found: No. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13. Personal alarm sounding when resident found: Yes. 14. Other residents were not involved in fall. j. Contributing factors note: 1. Resident utilized bed as support rather than walker. The Progress Note dated 3/23/24 at 4:20 (late entry- documented on 3/24/24 at 12:30 PM) revealed this nurse called to resident's room by CNA. This nurse entered room and resident sat upright in the middle of the room laughing. When asked what happened, resident laughed and stated I was hanging onto the bed, then I was on my butt. The resident denied pain, ROM (Range of Motion) intact following incident. Resident denied hitting head, no evidence indicating otherwise, but neuro's initiated per protocol. Resident assisted back to chair and had no further problems through the shift. The Neuro Assessment V3-V2 report revealed the following dates and times the neuro assessment not completed for the unwitnessed fall on 3/23/24 at 4:20 PM : a. second 15 minute check- resident not available for assessment due to resident at supper eating b. third 15 minute check- resident not available for assessment due to resident at supper eating c. fourth 15 minute check- resident not available for assessment due to resident at supper eating d. second 30 minute check- lacked documentation e. first hourly check- lacked documentation f. second hourly check- lacked documentation g. third hourly check- lacked documentation h. fourth hourly check- lacked documentation i. first 4 hour check- lacked documentation j. second 4 hour check- lacked documentation k. third 4 hour check- lacked documentation l. fourth 4 hour check- lacked documentation m. first 8 hour check- resident not available for assessment due to resident dined at breakfast n. third 8 hour check- dated 3/24/24 at 8:00 PM- lacked additional documentation o. fourth 8 hour check- dated 3/24/24 at 4:00 AM- resident not available due to resident in bed rested peacefully. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/24 at 10:54 AM, Staff B, LPN (Licensed Practical Nurse) queried on the neuro check assessment and she stated the neuro's charted under the assessments. Staff B stated when the resident at supper she didn't complete the neuro checks because nothing indicated she hit her head and didn't complain of a headache and nothing by her when the resident sat on the floor after the fall. During an interview on 4/1/24 at 1:52 PM, Staff A, LPN queried on the neuro checks for Resident #1 after the fall on 3/23/24 and she stated she knew about the fall and was told the resident didn't hit her head. Staff A stated she planned on doing the neuro checks but they didn't happen. She stated she looked at the times and was on the other side of the building administering medications and the times passed. She stated she thought only one or two of the neuro assessments needed during her shift. During an interview on 4/2/24 at 11:57 AM, Staff D, LPN queried on the protocol for an unwitnessed fall and she stated she looked at the resident's BIMS and if the BIMS low they started neuro assessments whether or not they thought the resident hit their head. Staff D asked if she conducted neuro checks when the resident was at meals and she stated yes she did unless the resident refused and she charted the resident refused. Staff D stated she woke the resident up for neuro checks unless she received an order not to wake them. During an interview on 4/2/24 at 3:28 PM, the DON (Director of Nursing) queried on the process for an unwitnessed fall and she stated if the BIMS less than 13, the nurses automatically started neuro assessments. The DON confirmed she reviewed the neuro assessment for the fall on 3/23/24 and saw all of neuro assessments not completed. The DON queried on her expectation of the neuro assessments and she stated the neuro assessments offered to the residents, but not pulled away from meals and if the assessment can wait to do it after the meal, and if the results were not normal, notify the provider. The Facility Neurological checks for head injuries policy/procedure dated 1/22/18 revealed the following information: a. Assess resident for changes in level of consciousness immediately after striking the head, then frequently throughout the shift for at least 72 hours. b. Observe the resident for obvious injuries to the scalp, including lacerations, bruises, or contusions; confusion, memory loss, difficulty speaking, gait or balance problems, pupils of unequal size or reactions, headache, vomiting, visual disturbances, or periods of coherence, alternating with periods of confusion or lethargy. c. Perform frequent neurological assessment every: 1. 15 minutes for 1 hour 2. 30 minutes for 1 hour 3. 1 hour for 4 hour 4. 4 hours for 16 hours (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. 8 hours until 72 hours elapsed and resident stable d. Neurological assessments include (at a minimum) pulse, respiration, and blood pressure; assessment of pupil size and reactivity, equality of hand grip strength, lower extremity motor functions, and pain level. The Facility Resident Fall Procedure (no date included) revealed the following information: a. If unwitnessed and/or resident hit their head, initiate neuro checks 1. A neuro check schedule sheet placed in the bottom filing drawer in Nurse Station B that helped establish time schedule for neuro checks, but they needed to be documented in EMR (Electronic Medical Record) also 2. Open up the Neuro Assessment under the assessment tab on the EMR for documentation of the vitals/assessments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on interviews, record review, and the facility policy, the facility failed to ensure the resident was supervised in her room while in a wheelchair which resulted in a fall for 1 of 4 residents reviewed for inadequate nursing supervision (Resident #1). The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #1 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS revealed resident dependent with toileting hygiene, and partial/moderate assistance with bed to chair transfer. The MDS revealed diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, mood disturbance, and anxiety. The MDS revealed the resident took opioids and used bed and chair alarms daily. The Care Plan revealed a focus area revised on 3/22/24 for assistance with ADLs (Activities of Daily Living) related to dementia, incontinence, pain, medication use that placed the resident at risk for falls/injury. The intervention dated 12/6/23 revealed due to a fall the resident won't be left in her wheelchair in her room unsupervised and would be transferred to her bed or recliner. The Care Plan revealed a focus area dated 1/10/24 that the resident had moderate risk for falls related to unaware of safety needs. The interventions dated 3/27/24 revealed following all activities, staff to assist the resident to her room and transferred her to bed or recliner to avoid resident assisting self to bed/recliner. The Progress Note dated 3/23/24 at 4:20 PM (late entry-documented on 3/24/24 at 12:18 PM) revealed the following information: a. Fall Details: Date/Time of fall: 3/23/24 at 4:20 PM: b. Fall not witnessed. The fall occurred in the resident's room. c. Activity at the time of fall: Resident moved self from piano bar into room without staff assistance and attempted to toilet self. d. Reason for the fall was evident. e. Did an injury occur as a result of the fall: No. f. Did fall result in an ER (emergency room) visit/hospitalization : No. g. Provider: [name redacted] Time notified: 03/23/2024 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Notified of: Fall Fall Details Note:Resident previously been in piano bar watching peers play cards. She proceeded to wheel self to room, closed door and attempted to transfer self to toilet. CNA (Certified Nurse Aide) [name redacted] found resident on floor with alarm sounding, sat in the middle of the room upright. This nurse called to room and resident laughed, sat upright in the middle of the floor. When asked what happened resident laughed and said I was hanging onto the bed, then I was on my butt. i. Contributing Factors: 1. Recent change in environment: No. 2. Was fluid spilled on floor: No. 3. Clutter present on the floor: No. 4. Floor mat was on floor: No. 5. Poor lighting in the area: No. 6. Bed was at an improper height: No. 7. Other furniture involved: Yes. Wheelchair was involved in the fall. Wheelchair unlocked at time of fall. Wheelchair footrest(s) were not in the way at the time of fall. 8. Wearing glasses at the time of the fall: Yes. 9. Footwear at time of fall: Shoes. Resident didn't use cane/walker as instructed. Resident used incontinence supplies at the time of the fall. 10. Incontinent at time of fall: No. 11. Bedside call light on when resident found: No. 12. Bathroom call light on when resident was found: No. 13. Personal alarm sounding when resident found: Yes. 14. Other residents were not involved in fall. j. Contributing factors note: 1. Resident utilized bed as support rather than walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 3/23/24 at 4:20 (late entry- documented on 3/24/24 at 12:30 PM) revealed this nurse called to resident's room by CNA. This nurse entered room and resident sat upright in the middle of the room laughing. When asked what happened, resident laughed and stated I was hanging onto the bed, then I was on my butt. The resident denied pain, ROM (Range of Motion) intact following incident. Resident denied hitting head, no evidence indicating otherwise, but neuro's initiated per protocol. Resident assisted back to chair and no further problems through the shift. The Incident Report #429 dated 3/16/24 at 4:20 PM titled unwitnessed revealed the following information: a. Nursing Description: This nurse called to resident's room by CNA. This nurse entered room the resident sat upright in the middle of the room and laughed. Pressure alarm sounded. Appropriate footwear on. When asked what happened, resident laughed and stated I was hanging onto the bed, then I was on my butt. Resident denied pain, ROM intact following incident. Resident denied hitting head, no evidence indicating otherwise, but neuro's initiated per protocol. Resident assisted back to chair and no further problems through the shift. b. Resident Description: Resident helped up off of floor, toileted, and removed from room. Staff not to leave resident unattended in 300 hall common area, only in country kitchens where staff is often near. c. Mental Status: oriented to person, place, and time d. Injuries report post incident: no injuries observed post incident e. predisposing environmental factors: fall alarm f. predisposing situation factors: ambulated without assist Reviewed the camera footage with the Administrator on 4/1/24 at 11:30 AM for the fall that occurred on 3/23/24 which showed the following timeline: a. 3/23/24 at 1:48 PM- resident self propelled in the 300 Hall b. 3/23/24 at 1:53 PM- resident turned the corner into the 200 Hall, c. 3/23/24 at 1:57 PM- resident at the other end of the 200 Hall d. 3/23/24 at 2:05 PM- resident self propelled into her room e. 3/23/24 at 4:10 PM- CNA took linen barrel into the resident's room. f. 3/23/24 at 4:15 PM- Staff B, LPN (Licensed Practical Nurse) came down the 300 Hall pushed her computer cart and went into the resident's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/24 at 11:38 AM, the Administrator stated Staff B texted her while in the room with Resident #1. The Administrator stated she received report that Resident #1 door shut. The Administrator confirmed the resident in her room alone until 4:10 PM before someone went into her room. The Administrator stated they generally shut the resident's door when the resident not in her room. During an interview on 4/1/24 at 11:55 AM, the Administrator queried on how often the CNAs do rounding and she stated they should do it every 2 hours and not more than 3 hours. The Administrator stated the resident ate at 4:30 PM and that was probably the reason the CNA went into her room. During an interview on 4/1/24 at 10:09 AM, Staff E, CNA stated she started doing rounds after her break on 3/23/24 and found the resident's door shut. She stated she went in her room and saw the resident fell and stayed with her until the nurse came into the resident's room and they got the resident up off the floor into her wheelchair. During an interview on 4/1/24 at 10:54 AM, Staff B, LPN (Licensed Practical Nurse) confirmed Resident #1 fell on [DATE] and she went into her room and assessed her and filled out the paperwork the following day. During an interview on 4/1/24 at 3:11 PM, Staff F, CNA queried on Resident #1 fall and she stated she worked that day and heard over the walkie the resident was on the floor in her room. Staff F stated if the resident was in her room she needed to be in her bed or recliner and the door needed to be open for the alarms. During an interview on 4/2/24 at 11:26 AM, Staff G, CNA confirmed Resident #1 cannot be in her room in her wheelchair by herself and that the resident's door should be open unless doing cares. During an interview on 4/2/24 at 3:10 PM, Staff H, CNA confirmed Resident #1 couldn't be in her room alone in her wheelchair and if she saw the resident in her wheelchair in her room she would bring her out to the into dining room area. During an interview on 4/2/24 at 3:28 PM, the DON (Director of Nursing) queried on if Resident #1 was allowed in her room unattended in her wheelchair and she stated they told the staff the resident couldn't be in her wheelchair in her room unattended and if they saw her in her room to ask if she needed toileted and then transfer her to the bed or recliner. The DON stated she expected staff to take the resident back to her room after meals and transfer her to the bed or recliner. The Facility Fall Risk Policy dated 2/12/17 revealed the following information: a. Procedure: 1. Upon admission, residents had a comprehensive assessment, including fall risk assessment tool within 14 days of admission. The MDS instrument identified specific resident problem areas or needs. Other criteria taken into consideration as followed: resident fallen in past week; or/and resident with underlying pathology causing falls. Resident had a recent decline in physical functioning or lacked insight into their limitations. Appropriate approached and interventions addressed on care plans. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Planning Policy dated 5/8/18 revealed the following information: a. Care Plan interventions designed after careful consideration of the relationship between the resident's problem area and their causes. When possible, interventions address the underlying source of the problem areas.