STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Savannah Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on record review, staff interviews, and the facility policy, the facility failed to ensure the chair/bed alarms worked properly one resident (Resident #3) and failed to implement new interventions in an effort to limit falls for 3 of 3 residents (Resident#1, Resident #2, and Resident #3) reviewed for supervision related to re-occurring falls The facility reported a census of 30 residents.Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated resident used a manual wheelchair and walker and independent with mobility. The MDS revealed medical diagnoses for acute respiratory failure, anxiety disorder, and depression. The MDS revealed resident took antidepressant and opioid medications. The Care Plan revealed a focus area dated 10/17/24 for resident had an actual fall due to sleeping on the edge of bed. The interventions dated 4/4/25 indicated educated to not sit on the side of the bed. The Nurses Note dated 12/7/25 at 8:34 PM, revealed this nurse was called into residents' room by CNA (Certified Nurse Aide). Resident was laying on the floor next to his bed on his side. When asked what had happen resident stated that he was reaching for something on his table and slid out of the bed.The Nurse Note (late entry) dated 12/9/25 at 7:50 PM, revealed at 7:50 PM, called to resident room, upon arrival resident noted to be laying on floor. parallel to bed, body positioned on left side facing bed, head pointing to television, feet pointing to CPAP (continual positive airway pressure - a device used to treat sleep apnea) machine, resident reports he was sitting on edge of bed, leaning on right elbow watching television when his sheets started sliding off of bed, resident was unable to catch himself before he fell, bed appears less than 2 feet from ground, resident reports he fell on right shoulder, denies hitting head, bruising noted to right posterior upper back near armpit area, laceration noted to left lateral foot, no other injuries r/t (related) his fall noted at this time, resident does have old bruising from fall 48hrs (hours) prior.The Nurses Note dated 12/14/25 at 4:44 PM, revealed this nurse was walking resident 108 up to dining room for supper when resident 101 called out help. This nurse saw resident laying on left side with head towards feet of the bed on the floor, parallel with bed. The Nurses Note dated 12/17/25 at 7:19 AM, revealed at 00:10 AM called to resident room, prior to being called to resident room this nurse overheard loud bang and resident yell aw shit, upon arrival, resident found to be laying parallel to bed, head at foot of bed, feet facing head of bed, resident lying on left side. Denies hitting head, reports he bumped his chin on wheelchair, bruising starting to form on chin, reports he also bumped feet on bedside table. skin tears noted to 2nd and 3rd right toes. When inquiring about what happened resident reports he was about to stand up to go to the bathroom when he slipped in something wet upon further inspection of surroundings, appeared water was spilled on floor at bedside, resident has multiple bruising noted from prior falls including bruising to right hip, bruising to left chest under breast, bruising to left flank and bruising to right upper back near axilla that are in various healing stages. The Nurses Note dated 12/19/25 at 00:30 AM, revealed at 00:30 called to resident room, upon arrival, resident laying on back on floor, parallel to bed, with head at foot of bed, top of head facing television, feet facing head of bed, gripper socks noted to feet, resident reports he was going to get (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up to his wheelchair when he dozed off and rolled out of bed, denies hitting head, reports scarping left knee when rolling out of bed, upon inspection, scab to left knee from prior fall was reponed, area cleansed xeroform applied, padded gauze applied and taped, scab to right knee from prior fall remains intact, no other new injuries noted, continues to have various stages of bruising to chin, and thoracic from prior falls. The Nurse Note dated 12/19/2025 at 8:46 PM, revealed at 7:45 PM, called into Resident room, upon arrival resident sitting on floor, with body perpendicular to bed, watching TV. Resident had socks on both feet, resident reports that he slid out of his bed and onto the ground. The Nurse Note dated 12/21/25 at 00:45 PM, revealed at 00:20 AM called into resident's room, upon entering the room, resident was found sitting on the floor in an upright position on the floor next to the bed. Resident reports he was going to get up to his wheelchair and slid out of bed. Resident denies hitting his head, and no new injuries were located upon assessment. Resident has various stages of bruising to his chin, stomach, and extremities all due to prior falls.The Incident Reports reviewed for the falls above and lacked documentation of interventions put in place at the time of the fall. The Care Plan reviewed and lacked documentation of the falls or for any new/revised interventions for Resident #1. 2. The MDS assessment dated [DATE] revealed Resident #2 scored a 12 out of 15 on the BIMS exam, which indicated cognition moderately impaired. The MDS indicated resident used a walker and wheelchair and needed partial/moderate assistance with sit to standing; and chair/bed to chair transfer. The MDS revealed medical diagnoses for stroke, non-Alzheimer's dementia, and traumatic brain injury (TBI). The MDS indicated resident had 2 or more falls with no injury and 1 fall with injury, but not major injury since last assessment. The MDS indicated resident received insulin 7 out of 7 days and an anticonvulsant. The Care Plan revealed a focus area dated 1/17/25 for risk of falls related to gait/balance problems and ataxia. The interventions dated 1/17/25 indicated anticipate and meet the resident's needs; be sure the resident's call light within reach and encourage to use for assistance; and ensure resident wore appropriate footwear. The interventions revised on 10/16/25 revealed resident can be taken by staff for more supervision due to frequent falls and noncompliance to nurse station, around the building. The electronic health record (EHR) revealed the following Physician Order: Document behavior during shift r/t self-transfers, turning off alarms, etc.- two times a day dated 10/15/25The Nurses Note dated 12/11/25 at 6:02 PM, revealed at approximately 6:55 AM resident was standing in hallway waving at this nurse, with no wheelchair or walker. RN (Registered Nurse) requested assistance from NOC (night) nurse, who stood by resident while this nurse obtained WC (wheelchair). Resident was seated in WC and responded yes when asked if he was ready for breakfast. This nurse and NOC nurse then turned around, facing away from resident. This nurse then looked back at resident and witnessed him lying on LT (left) side, having active seizure. Upon reviewing camera footage, it is notable that resident began seizure while seated in wheelchair, causing resident to fall from chair and hit head.The Nurses Note dated 12/13/25 at 10:34 AM, revealed this nurse was notified by ADON (Assistant Director of Nursing) [name redacted] that resident was on the floor. upon entering room resident was sitting on the floor with his legs in front of him.The Nurses Note (late entry) dated 12/15/25 at 9:45 AM, revealed this nurse was called to resident's room by staff. Upon entering room, resident was seated on floor parallel to bed, with his head underneath bedside table. Upon assessment, it was noted that resident hit LT side of head AEB (as evidenced by) laceration to LT eyebrow. Steri strips applied. The Nurses Note dated 12/18/25 at 2:35 PM, revealed this nurse was notified by CNA [name redacted] that resident was on the floor. resident sitting in front of desk with legs stretched out in front of him. his wheelchair a few feet away from him flipped backwards.The Nurses Note dated 12/21/25 at 11:35 AM, revealed this nurse was called to resident room by CNA [name redacted], stating that resident was on the floor. Upon entering room resident was sitting on the floor in front of his closet, with his feet out in front of him, and back resting on the closet door with CNA at his side. Resident denies hitting head, no new injury noted, resident denies pain, does however have scattered bruising and scabbing amongst his legs/arms from numerous falls over the last two weeks. The Nurses Note dated 12/26/25 at 10:24 AM, revealed this (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse was called to residents' room by CNA [name redacted]. Resident was sitting on the floor with back against bed, feet out in front of him. Wheelchair facing towards bed on the right side of resident.The Nurses Note (late entry) dated 1/1/26 at 8:30 AM, revealed this nurse was exiting room [ROOM NUMBER] when I heard a crash from country kitchen. RN went into country kitchen to find resident seated on floor next to recliner, with alarm sounding. Resident stated he was attempting to get into WC when the chair tipped over. Recliner was sitting upright at this time.The Nurses Note dated 1/4/26 at 7:50 PM, revealed nurse got called to 100 Dining Room/Country Kitchen at 7:28 PM by CNA, Resident was found sitting on the floor. Resident states he was trying to get to his wheelchair, which was too far away. Resident attempted to get out of the chair in the dining room to walk to his wheelchair which was approximately 5 feet from the chair at the time.The Nurse Note (late entry) dated 1/12/26 at 7:40 PM, revealed at 7:40 PM called to resident room, upon arrival resident parallel to bed, back facing tv, front facing call light box on wall, resident standing on 2 feet pushing hands off of floor to stand up, CNA stating wait for the nurse she's coming resident continued to stand self-up and get back into bed while this nurse was walking into room, resident noted to only have pull up and socks on, upon assessment skin tear noted to right elbow, hematoma and swelling also noted to area, resident denied any pain to area, bruising noted to right buttock, wheelchair noted to be unlocked and up against recliner with shoes in wheelchair.The Nurses Note dated 1/20/26 at 5:57 PM, revealed this nurse was called to the Country Kitchen on 100 Hall. Resident was sitting on buttocks with back against recliner.The Nurses Note dated 1/26/2026 at 4:10 AM, revealed resident had unwitnessed fall in resident room at 4:10 AM, resident was found by CNA sitting on floor next to bed perpendicular to bed. Resident denies immediate pain or discomfort from the fall. Resident states he was trying to get to the bathroom.The Nurses Note dated 2/8/26 at 10:02 AM, revealed this nurse heard alarm sounding, upon entering room resident was sitting on the floor with feet facing the East wall. parallel with the bed. Bed was raised all the way up, resident stated he did that. This nursed called for help to assist resident to wheelchair.The Nurses Note dated 2/8/26 at 5:50 PM, revealed resident was sleeping at the start of this shift. This nurse was coming back from the dining room and heard alarm sounding. Upon entering the room resident was sitting on the floor.The Nurses Note dated 2/13/26 at 9:45 PM, revealed this nurse was called into resident room by CNA, resident found on floor below his TV sitting upright. Resident's bed alarm was going off, but unable to be heard by staff due to resident turning TV and [NAME] to unacceptable levels, resident did change bed height from low so he could get up by self.The Medication Administration Note dated 2/14/26 at 5:08 AM, revealed . resident was found in bed during shift change, where resident resided until around 9:30 PM last night, when CNA called this nurse into residents' room. Resident had unwitnessed fall d/t (due to) not utilizing call light, raising bed to unsafe level, TV and [NAME] at unacceptable levels, which muffled the bed alarms beeps, and transferring without the assistance of staff. The Nurses Note dated 3/1/26 at 6:45 AM, revealed this nurse was exiting room [ROOM NUMBER] when I heard an alarm sounding, resident was standing in the country kitchen between his recliner and wheelchair. resident started to grab his wheelchair before falling and landing on his right shoulder.The Nurse Note dated 3/1/26 at 2:50 PM, revealed this nurse was at the nurse's station when alarm started sounding, this nurse and CNA [name redacted] ran to resident's room. resident was sitting on the floor in front of his bed with his legs out in front of him.The No Type Specified dated 3/8/26 at 1:38 PM, revealed resident found sitting on floor next to bed, with resident's shoes on. with resident stating that he slowly sat down on the ground.The Nurses Note dated 3/13/26 at 9:21 PM, revealed this nurse was called to resident room by CNA, upon entering resident room resident was laying on his back on the floor, next to his bed. Resident denies having any pain, but is actively bleeding from a laceration on the back/top of his head d/t hitting head on bedside table.The Care Plan lacked new/revised interventions for all the falls noted above. 3. The MDS assessment dated [DATE] revealed Resident #3 scored a 6 out of 15 on the BIMS exam, which indicated that cognition severely impaired. The MDS indicated resident used a walker and needed supervision/touching assistance with sitting to stand and chair/bed to chair (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer. The MDS indicated medical diagnoses for Type I diabetic mellitus, non-Alzheimer's dementia, anxiety disorder, and depression. The MDS indicated 2 or more falls with no injury since last admission. The MDS revealed resident took insulin 7 out of 7 days, antidepressant, antipsychotic, antianxiety. The Care Plan revealed a focus area revised on 5/2/25 for risk for falls related gait/balance problems. The interventions dated 4/18/24 indicated make sure alarm is in place and functioning properly. The EHR revealed the following Physician Orders - check to make sure alarms are in place and working four times a dayThe Nurses Note dated 12/7/25 at 2:07 PM, revealed this nurse called to residents' room by a member of housekeeping stating that the resident was sitting on the floor next to bed. Upon entering the room resident was sitting on her bottom with her back against the bed.The Nurses Note dated 2/8/26 at 7:16 PM, revealed resident had witnessed fall in resident room, by CNAs. Resident was ambulating by self to door to close her door and fell when she let go of her walker to close the door. Resident did hit back of head on bedstand, had a laceration to back of head.The Incident Report dated 2/8/26 at 6:05 PM, revealed resident's chair alarm was not going off at the time of the fall.The Nurses Note dated 3/21/26 at 00:15 PM, revealed this nurse found the resident found sitting upright on floor beside bed, with emesis all over resident's clothes and ground in front of resident. Resident denies hitting head and refers to getting out of bed via sliding instead of standing and falling. Resident's bed alarm was plugged in and working but wasn't going off when resident was found on the floor. Resident unable to state when emesis or fall occurred.During an interview on 4/1/26 at 9:26 AM, the MDS Coordinator/RN queried on Resident #1 and fall interventions and the MDS Coordinator stated Resident #1 was not always compliant and was able to transfer himself into his wheelchair at one point. The MDS Coordinator stated Resident #1 would scoot himself over in bed and then would be on the floor. The MDS Coordinator stated the facility used education, call light in place and an appropriate mattress as fall interventions. During an interview on 4/1/26 at 9:26 AM, the MDS Coordinator/RN queried on what the process is after a fall occurred and the MDS Coordinator stated the nurse did the report and intervention for the incident report and assessed the situation. The MDS stated a lot of time the intervention was reeducation. The MDS Coordinator queried on who can update the care plan and the MDS Coordinator stated she used one day a week and updated care plans for the residents who had MDS coming up and had triggered items. The MDS asked if she attended the morning meetings and the MDS Coordinator stated she worked part time and not the person who addressed the falls on the care plan to see if the residents needed new interventions. The MDS Coordinator stated she did not go back and see how many falls residents had or if they had interventions in place. During an interview on 4/1/26 at 9:26 AM, the MDS Coordinator/RN queried on Resident #3 fall interventions and the MDS Coordinator stated Resident #3 had the call light within reach, alarms, and everything Resident #3 needed around her. During an interview on 4/1/26 at 9:26 AM, the MDS Coordinator/RN queried on Resident #2 multiple falls and the MDS Coordinator stated Resident #2 was an interesting soul. The MDS Coordinator stated Resident #2 was pretty much a 1:1 and not compliant with a lot of anything. The MDS Coordinator stated there was not a lot the facility could do for him. The MDS Coordinator stated she worked a couple of evening shifts and pretty much sat at his door. The MDS Coordinator stated the staff would sit Resident #2 in the country kitchen and give him a bell, make sure he had food and drink to keep an eye on him. The MDS Coordinator stated she didn't know what else the facility could do for Resident #2 except for what they have already done. During an interview on 3/31/26 at 4:26 PM, Staff A, Licensed Practical Nurse (LPN) queried on any issues with alarms with Resident #3 and Staff A stated yes, a few times. Staff A stated the alarms were plugged and the facility used two different alarms. Staff A stated one alarm was white and the other one brown. Staff A stated the white alarm had a red light that told you it was working and the brown one would beep, but had a tendency to have a delayed response or doesn't go off. Staff A stated he tried replacing the brown alarms with the white box. Staff A stated the Director of Nursing (DON) aware and told him to use the white box. Staff A queried on the interventions for Resident #3 and Staff A stated using alarms and Resident #3 room (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was near the nurse's station. During an interview on 3/31/26 at 4:26 PM, Staff A, LPN queried on Resident #2 fall interventions and Staff A stated Resident #2 was usually a 1:1 with med pass. Staff A stated Resident #2 confused at baseline and thinks he can walk by himself. Staff A stated staff kept Resident #2 wheelchair close to the bed so he didn't have to walk along with the urinal and call light. Staff A stated Resident #2 usually got up between 2-3 AM and then didn't have a good explanation on why Resident was on the floor.During an interview on 4/1/26 at 10:02 AM, Staff B, LPN queried on what the nurse does after the fall and Staff B stated the staff tried to figure out the cause or an intervention. Staff B queried how an intervention was relayed to other staff and Staff B stated through spot charting in the progress note and passed on in report. During an interview on 4/1/26 at 10:02 AM, Staff B, LPN queried on fall interventions for Resident #2 and Staff B stated redirection, sitting Resident #2 in the recliner in the country kitchen to keep closer eye on him, engage in an activity. Staff B asked if Resident #2 needed 1:1 supervision and Staff B stated not necessary a lot and it depended on the day. Staff B stated sometimes Resident #2 had great days and other days, Resident #2 up and down a lot. During an interview on 4/1/26 at 10:02 AM, Staff B, LPN queried on where the fall interventions were found and Staff B stated she was sure there was a spot for interventions. Staff B asked if floor nurses could update the care plans and Staff B stated she was not 100% sure. Staff B stated the nurses could go into risk management and review the incident reports, but wasn't sure about the care plans. Staff B stated she thought the facility said something about nurses adding to the care plan if needed.During an interview on 4/1/26 at 10:25 AM, Staff C, CNA queried on where to find the fall interventions and Staff C stated usually with communication with the nurses or the Kardex. During an interview on 4/1/26 at 10:39 AM, Staff D, CNA queried on where to locate fall interventions and Staff D stated she spoke to the other CNAs and the nurses who had more interactions with the residents. Staff D stated she was the bath aide and did not do rounding and didn't know when residents fell unless other staff told her. During an interview on 4/1/26 at 11:02 AM, the Director of Nursing (DON) queried on the management process after a fall and the DON stated her and the Administrator read through the incidents and signed off on them. The DON stated the MDS Coordinator reviewed care plans every week and interventions. The DON asked when the care plan needed updated for falls and the DON stated ideally when the fall occurred. The DON queried on interventions with Resident #2 and the DON stated they tried everything under the sun like activities, alarms, and sign in his room for reorientation. During an interview on 4/1/26 at 11:07 AM, the Administrator stated they talked about falls at the daily meetings and if any issues and interventions. The Administrator stated it was hard to find interventions for resident who fell all the time. The Administrator stated recently the facility supervised Resident #2 at a higher level and educated staff to check on him more often. During an interview on 4/1/26 at 11:07 AM, the Administrator queried on the chair alarms not working properly for 2 falls with Resident #3 and the Administrator stated on the Medication Administration Record, it showed the alarms working properly. The Administrator stated she wasn't sure why they didn't go off and staff needed to be checking them. The Administrator queried if the facility did a root cause analysis and the Administrator stated no, not on paper. The Administrator stated they went through and talked about it. The Administrator stated the facility stepped up their game and reviewed 2 months of Resident #2 falls and seen who was working and the time of day and if that was the root cause analysis, they did do that. During an interview on 4/1/26 at 12:17 PM, the ADON queried if she attended morning meetings and the ADON stated yes. The ADON stated they review the falls and try to find the root cause but Resident #2 was so unpredictable. The ADON asked where the conclusion of the root cause was found and the ADON stated she felt the most of the falls happened at night and the staff couldn't get to Resident #2 fast enough. The ADON asked about fall interventions for Resident #2 and the ADON stated she didn't know what else the facility could do except for a 1:1 at all times. During an interview on 4/1/26 at 12:35 PM, the DON stated they did review the falls and see if any patterns and she wasn't sure if interventions like being in a more common place, bell he can ring were on the care plan or not. The DON stated she had not personally (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	put interventions in for falls, but should be done when the fall happens. The DON asked what she did after reviewing the fall on the risk management and the DON stated she didn't have a solid answer for that. During an interview on 4/1/26 at 12:35 PM, the DON asked what conclusion did they have for the alarms not going off and the DON stated she couldn't tell me 100%. The DON stated she didn't know the immediate action and the nurses were supposed to put an immediate intervention. The DON stated she was confused because the checking the alarms were checked off every day. The DON stated she did not go and personally check the alarms or ask if someone shut it off, or maybe the resident slid off the bed with the pad. The DON stated she didn't specifically interview the nurse after it happened. During an interview on 4/1/26 at 12:35 PM, the DON stated the nurses on the floor can add to the care plan and were supposed to update the care plans after the falls. The Facility Resident Fall Procedure (no date identified) revealed:Resident Fall Procedure.post fall intervention in your progress notes within 1 hour of the fallPost Fall Intervention Suggestions .Make sure these are resident specific and appropriate