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	08/25/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and the facility policy, the facility failed to care for a resident in a dignified manner by not emptying her bedside commode after providing toileting assistance for 1 of 3 residents reviewed for dignity. The facility reported a census of 34 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated Resident #40 dependent with toileting hygiene and chair/bed to chair transfer. The MDS revealed Resident #40 occasionally incontinent of bladder and always continent of bowel. Review of the Care Plan revealed a Focus area dated 11/7/24 for needed assistance with Activities of Daily Living (ADL's) related to Chronic Obstructive Pulmonary Disease (COPD) which places me at risk for falls/injury. The Interventions dated 10/23/24 included Resident #40 used a mechanical lift with a 2 assist with all transfers and dependent with assist x 1 with wheelchair mobility . During an interview on 8/21/25 at 10:46 AM, Staff A, Certified Nurse Aide (CNA) queried if she ever noticed the bedside commode in Resident #40 room not emptied after use and she stated sometimes she noticed it in the mornings. Staff A explained she would empty it after third shift. Staff A stated she didn't know if the Director of Nursing (DON) or the Administrator knew about it. During an interview on 8/21/25 at 10:59 AM, Staff B, CNA queried if she ever noticed the bedside commode in Resident #40's room not emptied after use and she stated at least one time when she came into work in the morning. Staff B stated Resident #40 had the call light on and when Staff B walked in the room and noticed. Staff B stated Resident #40 aware of the bedside commode not been emptied and commented about it, so Staff B made sure to take care of it. During an interview on 8/21/25 at 2:23 PM, Staff C, CNA queried about Resident #40 bedside commode not being emptied and she stated when she came into work, the bedside commode would still have urine and bowel in it. Staff C stated she told the nurses at least 3 times, but didn't remember which ones. During an interview on 8/25/25 at 9:36 AM, the DON queried if she knew about Resident #40 bedside commode not being emptied and the she stated she had never been told it was an issue. The DON stated she didn't see it happening because the DON and Administrator made frequent trips in the hall and they would smell it. The DON stated it is the expectation that after a bedside commode is used, it is removed and immediately cleaned. During an interview on 8/25/25 at 10:10 AM, Staff D, CNA queried on Resident #40 bedside commode not being emptied and she stated yes. Staff D explained the bedside commode had been used and not cleaned multiple times by different staff members. She stated she did not tell a nurse as in the past when she told a nurse of a concern nothing was done. Staff D stated two out of the three days in a week Staff D worked, she noticed the bedside commode not being emptied when she worked Resident #40 hall. Staff D stated she never told the DON or Administrator. During an interview on 8/25/25 at 11:04 AM, the Administrator informed of the interviews concerning the bedside commode and the Administrator stated she didn't remember anyone telling her about the issue. The Administrator stated if it happened, she didn't understand why the staff didn't report it to her so she could address the issue. The Facility Resident Rights Policy dated 12/12/16 revealed: a. A facility must treat each resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident family and staff interview, the facility failed to notify a family member prior to a chest x-ray being performed and failed to notify the physician a resident returned to the facility after hospitalization in a timely manner for 2 of 2 residents (Resident #18 and Resident #8) reviewed for notifications. The facility reported a census of 34 residents. Findings include: 1. The Minimum Date Set (MDS) assessment dated [DATE] revealed Resident #18 scored a 1 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The MDS listed a medical diagnosis of traumatic brain injury. Review of the electronic health record (EHR) Nurse Note dated 8/8/25 at 8:32 AM, revealed [name redacted] provider in house, gave verbal orders for chest X-ray due to residents increased coughing and congestion. Review of the X-Ray Report dated 8/8/25 at 11:02 AM indicated: a. Impressions: 1. Exam: 2 views of the chest; 2. Indication: Increased cough; 3. comparison: no prior radiograph; 4. Findings/Impression: Chronic fracture at the posterior aspect of the right fourth and fifth ribs. No cardiomegaly. No pneumonia. No definite pleural effusion. Calcification thoracic aorta. Streaky opacity at the left lung base representing infiltrate versus atelectasis. Mild increase in bilateral interstitial opacities. Review of a Provider Progress Note dated 8/11/25 at 8:44 AM revealed an order for a Z-pak (azithromycin- antibiotic). A Provider Progress Notes dated 8/12/25 at 11:07 AM, documented Z-pak ordered. Review of a Nurse Note dated 8/16/25 at 11:19 AM, revealed spoke with daughter [name redacted], wants Z pack DC (discontinued) as she states resident doesn't need it, will notify provider During an interview on 8/18/25 at 2:30 PM, the family representative stated the facility had not called her and updated her on a few things concerning Resident #18. The family member stated 2 weeks ago Resident #18 had a cough and the facility did a chest x-ray and the family member did not become aware of the chest x-ray until the facility called to inform her of the order for antibiotics after the antibiotics were started. During an interview on 8/21/25 at 12:24 PM, Staff E, Licensed Practical Nurse (LPN) queried on who conducted family notifications and Staff E stated the nurse who puts in the order. Staff E asked about Resident #18 chest x-ray order and Staff E stated the daughter came in and told Staff E the daughter did not get notification of her dad's chest x-ray and didn't want Resident #18 on antibiotics. Staff E stated the facility policy was to notify the family with any new medication orders or changes. During an interview on 8/21/25 at 3:00 PM, Staff F, LPN queried on family notifications and Staff F stated the nurse on shift made the calls to the families. Staff F stated she typically stayed over to make her family notification calls and documented them. Staff F stated she received the order for Resident #18 chest x-ray as she walked out the door in the morning because Staff F saw the provider. Staff F stated the day nurse was supposed to notify the family because Staff F was ending her shift. During an interview on 8/25/25 at 9:49 AM, the Director of Nursing (DON) queried on which staff notified the family of changes and the DON stated she notified the family as she put the orders in. The (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated the nurse needed to document family notification and the facility was working on educating the nurse to do more documentation. The DON stated she expected nursing staff to notify the families of changes and document when completed. During an interview on 8/25/25 at 11:01AM, the Administrator confirmed Resident #18 family was not notified of the chest x-ray. The Administrator stated the night shift nurse received the order and the day shift nurse was supposed to call the family and the task was not completed. 2. Review of the MDS assessment, dated 7/11/25, revealed Resident #8 with a BIMS score of 15 out of 15, which indicated intact cognition. The list of diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, chronic respiratory failure with hypoxia, seizure disorder, and anxiety disorder. Review of a the EHR revealed a Nurses noted entered on 8/1/25 at 5:03 PM Late Entry: Verbal orders received from [name redacted, provider] to send resident to ED (emergency department) to evaluate for hypoxia (low oxygen). EMS (emergency medical services) en route to the facility at this time. Review of a LTC Evaluation note, dated 8/04/25 at 10:56 PM, documented the reason for the evaluation was for 72-hour post hospital stay. The note revealed that Resident #8's lung sounds were diminished in the front and back lobes and identified that Resident #8 had a small pneumothorax (collapsed lung) to the left lung, without placement of chest tube, due to small size. The note revealed that Resident #8 had a displaced rib fracture to the left chest and had complaints of pain in left ribs, was given narcotic (oxycodone) medication due to non-pharmacological pain relief. The note documented that Resident #8 also received treatment in the hospital for pneumonia (lung infection). Review of a LTC Evaluation note, dated 8/05/25 at 11:40 PM, revealed that Resident #8 had difficulty breathing, shortness of breath, and used abdominal muscles to breath. The note documented that Resident #8 had a moist, loose cough with moderate amount of secretions produced. Review of a General (nursing) note, dated 8/06/25 at 5:01 AM, documented that discharge orders were found in Resident #8's bag from the hospital with new orders received to start azithromycin (antibiotic) two tablets for one day, cefuroxime (antibiotic) one tablet twice a day for one day, Prednisone (anti-inflammatory) 20 milligrams (mg), 1 tablet for 3 days, and ipratropium-albuterol nebulizer treatment 4 times daily. The note documented that Resident #8 was made aware of these orders. Review of a hospital discharge summary, printed on 8/04/25, revealed the following instructions listed, in part: a. Patient to return to nursing facility. b. Start to take oral cefuroxime 500mg, with instructions to give 1 tablet two times a day, for one day, to be taken on 8/05/25. c. Start to take oral azithromycin 250mg, with instructions to give 2 tablets one time a day, for one day, to be taken on 8/05/25. d. Start to take oral prednisone 20mg, with instructions to give 1 tablet one time a day for 3 days, to be started on 8/05/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Start to take Ipratropium Albuterol 0.5mg-2.5mg per 3 milliliters (mL) inhalation solution, with instructions to inhale 3mL four times each day, to be started on 8/04/25. The hospital discharge summary revealed a handwritten nursing signature, dated 8/06/25, which noted when the new orders were received. Review of Resident #8's Medication Administration Record (MAR), dated between 8/01/25 and 8/21/25, documented, in part: a. Azithromycin 250mg: Date of administration recorded on 8/06/25. b. Cefuroxime 500mg: Date of administration recorded on 8/06/25. c. Prednisone 20mg: Dates of administration recorded on 8/06/25, 8/07/25, and 8/08/25. d. Ipratropium-Albuterol inhalation solution 0.5mg-2.5mg per 3mL: Order start date: 8/06/25. Review of Resident #8 EHR's lacked physician notification of hospital discharge orders not started on 8/05/25, as ordered, but instead started and administered on 8/06/25. During an interview, on 8/21/25 at 3:05 PM, Staff F, Licensed Practical Nurse (LPN), confirmed working with Resident #8 on 8/06/25 and recalled Resident #8's hospital discharge orders were found in a bag in his room. Staff F stated she entered in the discharge orders to start right away and was unable to recall if the orders had any specific start date. Staff F denied notification sent to Resident #8's primary care provider eue to the orders that were found, were from a hospital provider. During an interview, on 8/21/25 at 3:55 PM, Staff G, Registered Nurse (RN), confirmed working with Resident #4 on 8/04/25, and recalled assessing Resident #8's respiratory status following return from the hospital but denied completing any re-admission paperwork or assessments upon his return to the facility. Staff G stated resident admissions were typically completed by office staff, but that recently floor nursing staff were being trained on how to complete admissions. Review of the undated facility policy titled, Routine Documentation directed, in part: Complete and thorough documentation is key to providing quality patient care. All important information needs to be documented in [name redacted] as a Progress Note (Nurse Note) so that it can be pulled to the 24 hour/72 hour report for shift report, supervisory review, and overall patient care review. Many instances justify documentation, whether it be something out of the norm, new/changed/worsening condition, monitoring, conversation with provider or family, etc. Below you will find a list of some things that should be documented, though this is not inclusive. If you didn't document it, it didn't happen and it's not realistic to think you will be able to remember 5 months (or years) from now. If in doubt, put a note in! a. Communication with provider (and outcome, orders, etc.) b. Communication with family (and questions or concerns addressed, needing to be addressed, follow up needed, etc.)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, clinical record review, and facility policy review, the facility failed to provide notification of resident discharge/readmission status to a Long Term Care Ombudsman for 3 of 3 residents (Resident #2, Resident #8, and Resident #38) reviewed for discharge process. The facility reported a census of 34 residents. Findings include:1. Review of the Minimum Data Set (MDS) assessment, dated 7/25/25, revealed Resident #2 was unresponsive, or unable to complete Brief Interview for Mental Status (BIMS). Resident #2 required full dependance on staff assistance for care needs. The list of diagnoses included anoxic brain damage, quadriplegia (loss of movement to all extremities), and epilepsy. Review of Resident #2's Electronic Health Records (EHR) revealed a list of MDS assessment completed, in part: a. On 4/13/25, a Discharge- return anticipated, assessment was completed. b. On 4/23/25, an Entry assessment was completed. c. On 5/18/25, a Discharge- return anticipated, assessment was completed. d. On 5/24/25, an Entry assessment was completed. 2. Review of the MDS assessment, dated 7/11/25, revealed a BIMS score of 15 out of 15, which indicated intact cognition. The list of diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, chronic respiratory failure with hypoxia, and seizure disorder. Review of a General (nursing) note, dated 8/01/25 at 4:46 PM, revealed that a verbal order was received from provider to send Resident #8 to the emergency department to evaluate hypoxia (low oxygen levels) and at 7:29 PM, the family was notified that Resident #8 returned to the hospital. Review of a Long Term Care (LTC) Evaluation note, dated 8/04/25 at 10:56 PM, documented the reason for evaluation was for 72 hour post hospital stay. Review of Resident #8's Electronic Health Records (EHR), lacked MDS assessment completed for discharge to the hospital on 8/01/25, and further lacked completion of an entry assessment upon return to the facility, from the hospital, on 8/04/25. Review of Resident #8's EHR revealed a list of completed clinical nursing assessments, which included a Transfer Form, dated 8/01/25, for discharge to the hospital. 3. The MDS assessment, dated 6/10/25, revealed Resident #38's list of diagnoses included congestive heart failure (CHF), acute respiratory failure with hypoxia, and atrial flutter. Review of Resident #38 EHR, revealed an admission date of 5/30/25 and a discharge date of 6/10/25. Review of Resident #38's EHR revealed a list of completed clinical nursing assessments, which included a Transfer Form, dated 6/10/25, for discharge to the hospital. Review of a General (nursing) note, dated 6/10/25 at 7:16 PM, documented that Emergency Medical Services (EMS) left facility with Resident #38 at 7:15 PM and were given Transfer Form, resident's (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order summary, and face sheet. The note revealed that physician was made aware of resident's transfer to the hospital. Review of a General note, dated 6/17/25 at 5:06 PM, revealed hospital updated facility that Resident #38 would be transferring to another facility. Review of an electronic mail (email), sent by facility administrator on 8/20/25 at 3:19 PM, stated that the only Ombudsman notification list of residents discharged for the year 2025, had been completed for April 2025. Review of an email, sent by facility administrator on 8/20/25 at 3:27 PM, stated that the April 2025, Ombudsman notification list was found to be blank. During an interview on 8/25/25 at 10:03 AM, the Business Office Manager confirmed she sent the Ombudsman Notifications and she forgot to do them this year. The Business Office Manager stated she knew they needed to be done and it was her fault the notifications did not get completed. Review of the facility policy, titled Discharging a Resident Procedure, revised on 8/06/2018, lacked step for Ombudsman notification of resident discharge.