STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445444	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savannah Nursing and Rehabilitation	1645 Florence Rd Savannah, TN 38372

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observation, and interview, the facility failed to maintain a clean and sanitary environment when small brown particles were found on top of the deep fryer and fryer basket, an oil like substance was observed dripping from the fryer onto the floor, a dark brown, gummy liquid was observed on the floor beside the deep fryer, loose particles and dried substances were found on the lids and down the sides of sugar, flour and meal storage containers and on metal storage racks, a dried, black substance covered the stove's cooking surface, the tabletop mini grill was covered with a dried, brown substance and loose particles and when a black substance was observed between the attached clear plastic barrier and the handwashing sink. The facility had a census of 88 with 85 residents receiving a tray from the kitchen. The findings include: 1. Review of the facility policy titled, Dietary Food Safety Requirements, revised 1/1/2026, revealed .It is the policy of the community.Food will be stored, prepared, and served in accordance with professional standards of food service safety. 2. Review of the facility policy titled, Dietary Cleaning, revised 1/1/2026, revealed .Adequate cleaning and sanitizing shall minimize the risk of food borne illnesses.The CDM [Certified Dietary Manager]/Kitchen Supervisor is responsible for maintaining a cleaning schedule to indicate which equipment and areas are to be cleaned and at what frequency.The CDM/Kitchen Supervisor shall audit the cleaning schedule for completeness.CDM/Kitchen Supervisor.shall conduct sanitation/safety inspection/kitchen observations. 3. Observations in the kitchen on 5/17/2026 at 9:15 AM and 2:50 PM, and on 5/18/2026 at 8:15 AM and 10:45 AM, revealed the following: a. Small brown particles were found on top of and inside the deep fryer, and fryer baskets. b. An oil-like substance was observed dripping from the fryer onto the floor and a dark brown gummy substance was observed on the floor to each side of the fryer. c. Sugar, flour, meal, and brown sugar were stored in four large plastic storage containers with clear lids, on the far back wall on the right side of the kitchen, with dried white substances and loose brown and white particles on top of the lids and down the sides of the containers. d. Metal storage racks were found with dried, splattered brown substances and tan particles on their surfaces. e. The stove surfaces were covered in a dried, burnt black substance. f. The tabletop mini grill had a sticky brown residue and brown particles inside. g. A black substance was observed between the clear plastic barrier that is attached to the side of the small sink where staff wash their hands. During an interview on 5/19/2026 at 8:20 AM, the CDM was asked if there should be a black substance between the clear plastic barrier and the sink. The CDM stated, No . The CDM acknowledged there should not be an oil-like substance and food particles on surfaces around the fryer, and dried, black buildup on the stovetop. The CDM was asked if the metal storage racks should have dried, splattered substances and food particles on their surfaces. The CDM stated .NO . The CDM was asked if the tabletop mini grill should have sticky brown residue and brown particles on its surface. The CDM stated No. The CDM was asked if the four large plastic storage containers with clear lids that stored the sugar, flour, meal and brown sugar should have dried substances and loose particles on top of the lids, and down the sides of the containers. The CDM stated no.

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to reimburse funds within 30 days to 1 of 1 (Resident #107) sampled residents reviewed for personal fund accounts. The findings include: 1. Review of the facility policy titled, Resident Personal Funds, dated [DATE], revealed .Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds and a final account of those funds to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law 2. Review of the medical record revealed Resident #107 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Dementia, Hypertension, Schizophrenia, and Acute Kidney Failure. Review of the Discharge summary dated [DATE], revealed .expired . Review of Resident #107's Resident Fund Account revealed, a returned check dated [DATE] was issued for the account balance of $4,394.97, 6 days past the allotted 30-day time period. The facility failed to refund the remaining balance to Resident #107's estate within 30 days of death. During an interview on [DATE] at 7:52 AM, the Assistant Business Office Manager was asked to explain the process of conveyance of Resident funds after a resident expires. The Assistant Business Office Manager stated, .We key it in the system [the refund request], then it takes 24-48 business hours for it to be submitted to [named Administrator] to approve, once he approves it the cash handler can go in and print it [the refund check].Once it is entered on our [Business Office] end it is out of our hands. During an interview on [DATE] at 8:17 AM, the Administrator was asked when a resident funds check should be sent. The Administrator stated, The check has to be sent back to the family within 30 days. The Administrator was asked if Resident #107's check sent within that time frame. The Administrator stated, It was not.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility competency review, medical record review, observation, and interview, the facility failed to ensure a resident with a percutaneous endoscopic gastrostomy (peg) tube (a feeding tube inserted through the abdominal wall directly into the stomach to deliver nutrition, fluids, or medications) received appropriate care and services to prevent complications for 1 of 1 (Resident #13) sampled residents reviewed for peg tube. The findings include: 1. Review of Licensed Practical Nurse (LPN) A's Medication administration via feeding tube competency check off sheet dated 8/15/2025, revealed .Check placement and gastric residual volume by auscultation [instilling air into the feeding tube with a syringe while using a stethoscope placed over the stomach to listen for rushing air] and aspiration [attaching a syringe to the open port of the feeding tube and gently pulling back to see gastric residual(stomach contents)].Satisfactory Performance. Review of the facility policy titled, Medication Administration, dated 1/1/2026, revealed .Medications administered via [by way of] feeding tube.Check placement and gastric residual volume by aspiration and auscultation. 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Diabetes, Traumatic Brain Injury, and Gastrostomy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 scored a 1 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was severely cognitively impaired. Resident #13 was assessed for the use of a Peg tube. Review of the Care Plan dated 4/22/2026, revealed .has nutritional problem or potential nutritional problem, has peg-has Regular diet with finger foods.Use Enhanced Barrier Precautions- peg. Review of the Physician's Orders dated 4/22/2026, revealed .Check placement of enteral tube per auscultation and aspiration .every shift related to GASTROSTOMY STATUS. Review of the Physician's Orders dated 4/22/2026, revealed .Baclofen TAB [tablet] 10mg [milligram] Give 1 tablet enterally one time a day for muscle spasms. Review of the Physician's Orders dated 4/22/2026, revealed .Gabapentin Oral Capsule 300 mg.Give 3 capsule enterally one time a day. Review of the Physician's Orders dated 4/22/2026, revealed .Flush enteral tube with 30 ml of water before and after medications. Review of the Physician's Orders dated 4/22/2026, revealed .May crush medications.and combine. Observation outside Resident #13's room during medication administration on 5/18/2026 at 12:50 PM, revealed LPN A checked the physician's orders, and gathered her supplies. LPN A performed hand hygiene, donned gloves, emptied the Gabapentin capsules into the medication cup, crushed the Baclofen and emptied into the medication cup, removed her gloves and performed hand hygiene. LPN A knocked on Resident #13's door and entered the room. LPN A placed a barrier on the over the bed table and placed her supplies on the barrier. LPN A washed her hands and donned a gown and gloves. LPN A stated that she was going to auscultate to check placement of the peg tube. LPN A connected the syringe without the plunger to the peg tube and placed the stethoscope onto the Resident's abdomen. LPN A then poured 30 milliliters (ml) of water into the syringe and let it flow per gravity. LPN A stated that the tube was patent. LPN A administered the medications and flushed with 30 cc of water. LPN A removed her gown and gloves, washed her hands and exited Resident #13's room. LPN A failed to follow facility policy and physician's orders for checking the placement of the peg tube before administering medications. During an interview on 5/18/2026 at 1:15 PM, LPN A was asked if Resident #13's peg tube should have been flushed with water to check placement. LPN A stated, We just did a competency check off on that. I may have gotten it mixed up. LPN A was asked if the peg tube was not in the correct placement, could a 30-cc flush of water potentially cause complications to the Resident. LPN A stated, Yes. During an interview on 5/18/2026 at 1:20 PM, the Director of Nursing (DON) was asked if she would expect the staff to check for peg placement by auscultating with a 30-cc water flush. The DON stated, No.I would expect them to follow physician's orders.