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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 11/6/2018 Investigative findings during an onsite investigation determined complaint #77758-C and facility reported incident #78556-I were substantiated with a deficiency as follows. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C	F 000	Please see attached. 11/12/18	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide adequate nursing supervision and assistance devices for 1 of 4 residents reviewed. Resident #4 admitted to the facility 8/10/18 with a history of falls and a left hip fracture. The facility implemented fall alarms in an attempt to alert staff when the resident attempted to stand unassisted and/or was on the move. However, Resident #4 removed his alarm and they did not sound. Staff noted the resident removed his alarms, but failed to implement additional supervision or other measures to mitigate the risk of the alarm(s) not sounding. On 9/15/18, Resident #4 removed his tab safety alarm and fell, which resulted in a fractured right	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Penny Moulton	Administrator	11/05/2018

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.

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1	F 689		

wrist, pain, a 2 day hospital stay, and a wrist splint. The facility reported a census of 36 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool dated 09/07/18, Resident #4 admitted to the facility on 08/10/18 and had diagnoses that included anemia, hip fracture, and non-Alzheimer's dementia. The MDS revealed the resident had a BIMS (Brief Interview for Mental Status) score of 4 out of 15 indicating severely impaired cognitive ability. The MDS documented the resident required extensive assist of one staff for bed mobility, ambulation (walking), dressing, and toilet use. The MDS also documented the resident required limited assist of one staff for transfers, ambulation in room, and personal hygiene, although ambulation did not occur. The MDS revealed the resident used a wheelchair and walker for mobility devices and had a functional limitation in range of motion to one side of his lower extremity that interfered with daily function or placed the resident at risk of injury.

The care plan with focus start date of 08/10/18 identified Resident #4 needed assist with ADL's (activity of daily living) related to recent fall prior to admission with fracture to left hip and weakness, which placed him at risk for falls/injury. The care plan indicated resident had a fall on 9/16/18 and injured his right wrist. The care plan included approaches/interventions that directed staff:

a) Initiated on 8/10/18: Staff to assist the resident with bed mobility and put bilateral upper side rails in place to assist resident with bed

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

mobility.
b) Initiated on 8/10/18: staff to assist resident with one to two staff members for dressing.
c) Initiated on 8/21/18: staff to stand with resident at sink with gait belt and four wheeled walker for hand washing, oral cares, combing hair, and shaving.
d) Initiated 9/18/18: resident to use a platform walker for transfers and ambulation and resident is to wear a Velcro adjustable wrist splint to right wrist.
e) Initiated on 9/18/18: resident had a personal alarm and bed alarm, but resident disconnected them at times.
f) Initiated on 9/18/18: staff to place a monitor for safety in the resident's room so they could hear if the resident stood unassisted while staff was at the nurse's station.

Review of the facility's Capstone Fall Screener dated 8/10/18 documented Resident #4's fall scoring as 55. A score of 4 or higher represented a resident at high risk.

Review of the resident's progress notes revealed the following:

a. On 8/15/18 at 11:49 PM: Documentation revealed the resident displayed restless behavior and the 2nd shift nurse initiated a clip alarm due to safety concerns.
b. On 8/16/18 at 1:11 PM, staff contacted the resident's family to inform them of resident attempting to transfer by himself and to notify family regarding the use of the clip alarm for safety.
On 8/21/18 at 12:36 AM: Staff documented the resident experienced confusion and wanted to do everything on his own. The "alarms" remained in

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

place because the resident attempted to stand unassisted.
c. On 8/22/18 at 1:37 PM: The RN wrote that therapy verbalized concerns regarding the resident's cognition during the Medicare Meeting. During the meeting, therapy reported the resident could transfer with assist of 1 or 2 staff and ambulated for short distances with assistance.
d. On 8/25/18 at 4:52 AM: The LPN documented summoned to the resident's room by CNA. The resident sat in his recliner with the bed alarm on the bedside table, turned off and folded neatly. The resident had transferred himself from the bed to the recliner and removed his clip alarm. Staff encouraged the resident to use the call light to ask for assistance.
e. On 8/27/18 at 4:33 PM: Documentation showed a visitor found the resident in the bathroom and had not used the call light to ask for assistance. The resident had transferred on his own and walked to the bathroom alone. Staff encouraged the resident to call for help for transfers.
f. On 9/15/18 at 7:13 PM: A CNA (Certified Nurse Aide) called Nurse into the resident's room and observed resident on the floor on his back. Resident agitated and denied hitting his head, but reported he had a broken wrist. The notes described the resident as confused. The nurse's assessment revealed the resident's right wrist was painful, swollen, and had the appearance of a possible dislocation; the resident also complained of back pain. The notes indicated the nurse attempted to call family and left a message, and also notified the resident's physician. The physician ordered staff to transfer Resident #4 to the emergency room for further evaluation and treatment. The ambulance transported the resident from facility to the emergency room.

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

g. On 9/15/18 at 10:17 PM: Staff spoke with Resident #4's family member and family reported awareness of resident's admission to the hospital for pain control.
h. On 9/17/18 at 2:30 PM: The nurse documented the resident returned to facility.

Review of report of Date of Incident 9/15/18 documented staff found Resident #4 on the floor via unwitnessed fall. The report noted the resident was known to take alarms off. Interventions in currently in place: alarms, nonskid footwear, signs in room for reminders for resident to use his call light, walker nearby, and adequate lighting. New interventions initiated include alarms are not able to be heard unless close to resident's room, resident is also known to take alarms off, baby alarm to be placed if not defective, maybe move closer to nurses station.

Review of Resident #4 hospital Radiology Report dated 9/15/18 at 7:57 AM documented history of resident with a fall and subsequent right wrist pain. The report's impression included diffuse osteopenia, impacted and angulated horizontal fracture through the distal metaphysis of the radius, displaced ulnar styloid fracture, and no definable carpal bone fracture.

An interview was conducted on 9/28/18 at 10:30 am with the Administrator. The Administrator's documentation dated 9/19/18 indicated CNA found Resident #4 on the floor in his room on 9/15/18. Resident immediately complained of right wrist pain; resident transferred to the emergency room via ambulance and was admitted to the hospital for observation until 9/17/18 for pain control. Resident's family decided

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

to not pursue surgical treatment. Resident returned to the facility with a wrist splint on. Resident is temporarily using a platform walker at this time. Administrator stated the resident had had no previous falls during his skilled care. The Administrator indicated due to the resident's impaired cognitive ability, staff provided cueing, reorientation, reminders, and provided supervision as possible. Staff also sat with the resident during periods of restlessness and provided 1:1 with staff. The Administrator indicated upon return to the facility an audio monitor was placed in resident's room with the base stationed at the nurses' station to alert staff of resident's movement and alarms sounds of resident.

Interview was conducted on 9/28/18 at 10:48 PM with Staff A, Certified Nurse Aide (CNA), along with her written statement regarding Resident #4. Staff A stated she came into work at 2 PM on 9/15/18 and was assigned in the hallway of Resident #4. Staff A stated she first saw Resident #4 shortly after 2 PM while she passed snacks to residents. Staff A stated at that time the resident sat in his chair reading a book had a bag of books on the floor beside him, a tab alarm in place, and his walker and call light within reach. Staff A stated she came out of a resident's room close to Resident #4's room and heard a noise. Staff reported another coworker was in the hallway assisting residents at the same time Resident #4 fell. Staff A stated she found Resident #4 lying on his back on the floor in his room, in front of his closet/desk. Staff A stated the resident was holding his wrist and he stated he fell. Staff A stated no alarm was sounding and reported she found his tab alarm on top of his desk and his bed pressure alarm in a dining room

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

chair in his room that she had not seen when she checked the resident earlier. Staff A stated the resident's call light was not on, gripper socks on remained on the resident's feet, and floor dry. Staff A stated she immediately summoned the nurse via walkie-talkie. Staff A reported the resident was known to remove his alarms or transfer by himself, carrying the alarms with him. Staff A stated therapy is working with the resident, and staff does education with resident he is found up unassisted, and there are signs in his room to remind him not to get up without using call light and waiting for assist.

Interview was conducted on 9/28/18 at 10:11 am with Staff B, Registered Nurse (RN). Staff B stated she was assigned to care for Resident #4 on 9/15/18 when he fell. Staff B indicated she had seen the resident 10 to 15 minutes prior to his fall as she administered medications. Staff B stated the resident sitting in his chair reading a book, tab alarm in place and call light in reach, and resident voiced no needs or wants at that time. Staff B stated she was in another hall when she was summoned to resident's room by staff and found the resident on the floor on his back. Staff B stated the resident complained of wrist pain and back pain. The resident's wrist was swollen and looked dislocated. Staff B stated she contacted the resident's physician who instructed to send resident to the emergency room for further evaluation and treatment. Staff B stated the resident was admitted to the hospital for a fractured wrist and for pain control. Staff B reported the resident appeared to have removed his tab alarm and placed it on his desk in his room. Staff B indicated the resident has a history of frequently removing his alarms, including tab alarm and pressure bed alarm or carrying the

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 _____	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

alarm with him. Staff B stated staff attempted to provide frequent checks on the resident when possible, but there was nothing documented.

Interview was conducted on 9/28/18 at 9:47 am with Staff C, Registered Nurse (RN), Assistant Director of Nursing (ADON) and Care Plan and MDS nurse. Staff C stated Resident #4 did have a bed alarm and a pressure alarm with a history of removing them. He also had signs in his room that reminded him to use his call light for assist. Staff C stated the alarms, his history of removing his alarms or his signs in the room to remind him to use call light were not placed on the care plan until 9/18/18. Staff C stated she is not sure when the alarms or the signs were implemented but that should have been on the care plan. Staff C stated after the resident's fall on 9/15/18, staff placed a baby monitor in the resident's room with the monitors in two of the nurses stations so staff can hear movement of resident or his alarms. Staff C stated this was not on the care plan until 9/18/18. Staff C stated the resident needs 1 to 1 supervision by staff at times, but this is not on the care plan.

Savannah Heights

Self Report

September 25 – October 25, 2018

Please accept this plan of correction as my credible allegation of compliance.

The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission or an agreement by the facility for the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction for the deficiencies was executed solely because it is required by provision of state and federal law.

F 689 The facility will provide adequate nursing supervision and assistance devices. Nursing staff have placed a monitor in Resident #4's room so they are able to hear if he/she gets up unassisted and the staff assigned for his/her care will carry the monitor on them while on duty except when a charge is needed. Resident #4 has now discharged to home. This will be monitored by the Director of Nursing or Designee on a monthly basis x2 months. QA committee will monitor this quarterly x2. Correction date: November 6, 2018.