

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/14/2025
NAME OF PROVIDER OR SUPPLIER  Thunderbolt Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  3223 Falligant Avenue Savannah, GA 31404	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record reviews, and a review of the facility's policies titled Abuse Prevention Policy &amp; Procedure and Identifying Sexual Abuse and Capacity to Consent policy, the facility failed to protect Resident (R) (101)'s right to be free from physical abuse by R2. The sample size was 22 residents.</p> <p>On February 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The Facility's Administrator, Director of Nursing (DON), Director of Clinical Operations, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on February 11, 2025, at 2:21 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on January 31, 2025.</p> <p>The IJ was ongoing at the time of exit on February 14, 2025.</p> <p>Findings include:</p> <p>Review of the facility's policy Abuse, Neglect and Exploitation; dated 4/1/2024, Policy Explanation and Compliance Guidelines: 3. The facility failed to provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written: IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations.</p> <p>The Abuse, Neglect and Exploitation; Abuse Prevention Standard included Resident to Resident Abuse which documented the facility would take all steps reasonable and necessary to protect the residents from harm at all times, including protection from any type of abuse listed from other residents.</p> <p>1. A review of the admission Record revealed R2 was admitted to the facility on [DATE] with the following diagnoses that include but are not limited to dementia with other behavioral disturbance, type 2 diabetes mellitus with diabetic nephropathy, and depression.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115624
		If continuation sheet Page 1 of 16

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the Minimum Data Set (MDS) Quarterly assessment for R2 dated 1/16/2025 revealed the resident had a BIMS indicating severely impaired cognitive skills, displayed behaviors continuously present for inattention and disorganized thinking, and required Partial/to substantial supervision assistance for Activities of Daily Living.</p> <p>2. A review of the admission Record revealed R101 was admitted to the facility on [DATE] with the following diagnosis: epilepsy, nontraumatic intracerebral hemorrhage, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, and anxiety.</p> <p>A review of the Quarterly MDS for R101, dated 9/27/2024, documented a BIMS of three, indicating severely impaired cognition.</p> <p>Review of the five-day MDS for R101, dated 1/10/2025, documented in section GG: dependent for toileting, shower/bath, and upper/ lower dressing. Substantial/maximal assistance: roll left and right, sit to lying, lying to sitting on the side of bed, sit to stand, and chair/bed to chair transfer.</p> <p>Review of a Nurse Note Progress Note dated 2/3/2025 documented that R2 wanders in and out of other residents' rooms throughout the night. The resident was redirected to the room every time. The resident started cursing at staff while trying to redirect her back to her room.</p> <p>Review of a Nurse Practitioner (NP) Progress Note dated 1/31/2025 at 3:14 pm revealed the resident was being evaluated for aggressive behavior. The nurse reported that there was an incident last night where R2 pulled another resident (R101) out of her bed and caused her to fall on the floor.</p> <p>Review of a Nurse Note Progress Note dated 1/31/2025 revealed R2 in doorway of room [ROOM NUMBER] with clothing off and resident (R101) noted on the floor. Resident (R2) began to swing and curse at staff. Refused to come out of resident's (R101) doorway.</p> <p>Review of a Behavior Note Progress Note dated 1/30/2025 documented, resident up all night in and out other resident's room. yelling at staff being verbally aggressive using profanity. going in staff belongings taken food. medicated x 1 with IM haloperidol shot. resident unable to be redirected.</p> <p>Review of Behavior Note Progress Note dated 1/25/2025 documented, Resident is verbally aggressive towards her roommate, making threats, using gross profanity, resident refers to roommate as a man, that has moved into her apartment, she wants him out, writer attempt to re-orient unsuccessfully, roommate c/o being afraid for her life, as a result of the misunderstanding, roommate was moved to room [ROOM NUMBER]-1 temporarily, attempt to notify family, left message.</p> <p>Review of Administration Note Progress Note dated 1/24/2025 documented, Haldol injection solution 5 milligram (mg)/milliliter (ml) Inject 0.5 mg/ml intramuscularly every 4 hours as needed for increased anxiety/agitation related to unspecified dementia, moderate, with other behavioral disturbance for 14 days resident combative and arguing with others and staff.</p> <p>Review of Behavior Note Progress Note dated 1/23/2025 documented, Resident wandering in and out of other resident's room, going through their personal belongings, when approached by staff, resident becomes argumentative and uses very vulgar language, refuses care i.e. wound care, she walks up to med cart, picks up the water pitcher and spills the entire thing, when spoken to about it, she gets very upset, starts to use profanity.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 2/6/2025 at 6:22 am with Registered Nurse (RN) XXXX recalled the incident that happened on 1/31/2025 between R101 and R2. RN XXXX revealed that during rounds on the early morning of January 31, 2025, she was supervising the facility after completing a walkthrough of the east and west wings, entered the memory care unit, and spoke with the Licensed Practical Nurse (LPN) on duty she informed RN XXXX that an incident had occurred earlier about 4:00 or 4:30 am. According to the LPN, the resident in room [ROOM NUMBER] A (R2), after removing her clothes, pulled the resident in room [ROOM NUMBER]A (R101) to the floor. She also reported that the resident (R2) was not wearing any clothes during the incident. RN XXXX stated that she immediately assessed the situation to ensure the safety of both residents. RN XXXX revealed asking the LPN why she had not been notified of the incident sooner so I could provide additional assistance. The LPN stated that she was unsure of my location within the building. The LPN informed RN XXXX that she had attempted to contact the physician along with hospice and notified the family member (FM) of the resident (R101). RN XXXX confirmed that the hospice and the resident's FM (R101) knew about the incident. RN XXXX stated she implemented appropriate measures after receiving the physician's order, including assigning resident (R2) one-on-one supervision to prevent further incidents. RN XXXX revealed that she continued to monitor this situation to maintain the safety and well-being of our residents.</p> <p>Interview on 2/6/2025 at 7:10 am with Certified Nursing Assistant (CNA) BBBB recalled the incident between R101 and R2 on 1/31/2025. CNA BBBB stated that at approximately 4:30 am, a resident in room [ROOM NUMBER]B began having an episode. She was screaming and repeatedly telling people to get out of her house. CNA BBBB stated that she and another CNA quickly responded to her distress to comfort and calm her, as we wanted to prevent disturbing the other residents. While in the room, we decided to assist the resident in room [ROOM NUMBER]B with washing up and dressing for the morning. CNA BBBB revealed that we heard a door locking sound around three minutes into assisting the resident in 202B. The other CNA went to investigate, and shortly after, I heard her call for assistance with residents in room [ROOM NUMBER]A (R101). I continued to assist the resident in 202B with getting dressed. CNA BBBB further revealed that after attending 202B, I was informed that 204A(R101) had been found lying face up, unclothed, while patient 205A(R2) was sitting in the recliner chair beside her. At this point, the nurse on shift instructed me to take 204A(R101) vital signs. I completed the task and reported the results back to the nurse.</p> <p>Interview on 2/6/2025 at 7:10 am with CNA CCCC recalled the incident between R101 and R2 on 1/31/2025. At approximately 4:30 am, a resident in 202 B began yelling and screaming, stating, Getting out of my house, a behavior that was not uncommon for her. The other CNA and I immediately responded to attempt to calm her down. While in the room with resident 202 B, I heard a door lock sound, which prompted me to investigate further. CNA CCCC stated that while checking the sound source, she discovered that resident 204-A (R101) was lying on her back while patient 205-A(R2) was sitting beside her. Both patients were undressed. She promptly called the nurse for assistance while removing patient 205-A(R2) from the room to ensure her safety and privacy. Once the resident in room [ROOM NUMBER]-A (R2) was removed, the nurse and I safely assisted the resident in 204-A (R101) back into her bed. CNA CCCC revealed that the nurse instructed the other CNA to take the vital signs of patient 204-A (R101), which were subsequently reported back to her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Phone interview on 2/6/2025 at 11:37 am with (LPN) YYYY recalled the incident that happened during her night shift beginning on 1/30/2025 but occurred early morning on 1/31/2025 between R101 and R2; she was called to the resident (R101) room by a CNA. LPN YYYY stated that R101 was lying on her back and buttocks on the floor. No injury was noted. She notified the physician of the incident. LPN YYYY revealed that R2 was in the resident's (R101) doorway with their clothing off. LPN YYYY stated she called hospice and R101's FM and notified him. She revealed that the supervisor was made aware of the situation. LPN YYYY revealed that she did not see R2 leave her room and walk to R101's room. LPN YYYY revealed that the hallway was dark because the lights were turned off.</p> <p>Phone Interview on 2/10/2025 at 12:00 pm with RN A2 reported the last time she saw the resident was on 1/30/2025 from 3:43 pm until 5:59 pm while completing R101's admission paperwork for hospice. RN A2 revealed that R101 was unable to do anything for herself; she was a total care resident. RN A2 further revealed that resident R101 was noted to be transitioning /actively dying because she had not eaten or drank anything other than a sip of water in the last seven days and was minimally responsive to voice stimuli. She stated that her pupils were fixed and did not track movement. The resident was very weak, and she required total care for all Activities of Daily Living (ADLs).</p> <p>Interview on 2/11/2025 at 11:17 am with the DON revealed that she instructed the staff to always keep R2 in their line of sight and that the nurses should do 15-minute checks. The DON revealed that the facility had ordered stop signs for the door to display for wandering residents to see. She revealed that she was not told about R2 wandering.</p> <p>Interview on 2/11/2025 at 11:17 am with the Administrator revealed she was not made aware of the abuse, and had she known, then she would have reported the abuse immediately.</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, record review, and the facility's policy titled Abuse, Neglect, and Exploitation, the facility failed to report an allegation of physical abuse for one resident (R) (R101). The census was 120.</p> <p>On February 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The Facility's Administrator, Director of Nursing (DON), Director of Clinical Operations, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on February 11, 2025, at 2:21 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on January 31, 2025.</p> <p>The IJ was ongoing at the time of exit on February 14, 2025.</p> <p>Findings included:</p> <p>A review of the facility policy titled Abuse, Neglect, and Exploitation dated 4/1/2024 revealed: The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes.</p> <p>A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R101 with a Brief Interview of Mental (BIMS) score of three, indicating severely impaired cognition.</p> <p>A review of the admission MDS dated [DATE] revealed R2 with a BIMS of three, indicating impaired cognition.</p> <p>Interview on 2/6/2025 at 7:10 am with Certified Nursing Assistant (CNA) BBBB confirmed her statement about the incident involving R101 and R2. She revealed that the resident had had behavior issues before this incident. CNA BBBB revealed that she only reported it to the nurse on duty.</p> <p>An interview on 2/6/2025 at 7:35 am with CNA CCCC confirmed her statement regarding R101 and R2's incident. CNA CCCC revealed that when she arrived in R101's room, she was lying flat on her back on the floor, and R2 was sitting next to her on a chair in the room. After the nurse entered the room, they picked R101 up off the floor and placed her back in the bed. CNA CCCC revealed that the nurse was the only person she reported it to.</p> <p>Interview on 2/11/2025 at 11:17 am with the DON revealed that she did not report the incident involving R2 and R10.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 2/11/2025 at 11:17 am with the Administrator revealed that a reportable was not submitted on time. The Administrator confirmed that she is the Abuse Coordinator and was unaware of the allegations of abuse. The Administrator revealed that if she had known of the abuse, she would have reported it immediately.</p> <p>A review of facility reported incidents showed no evidence that the allegation of physical abuse was not reported.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, record reviews, and a review of the facility's policy titled Abuse Prevention Policy &amp; Procedure, the facility failed to conduct a thorough investigation and implement protective measures in a timely manner following an allegation of resident-to-resident physical abuse involving two Residents (R) (R101 and R2). The census was 120.</p> <p>On February 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The Facility's Administrator, Director of Nursing (DON), Director of Clinical Operations, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on February 11, 2025, at 2:21 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on January 31, 2025.</p> <p>The IJ was ongoing at the time of exit on February 14, 2025.</p> <p>Findings include:</p> <p>The facility had an Abuse Prevention Policy &amp; Procedure,</p> <p>Section 4 of the policy titled Resident-To-Resident Policy documented that it is the policy of the facility to take all steps reasonable and necessary to protect the residents from harm at all times, including protection from physical and verbal abuse from other residents. Number 8 of the Procedure portion of the Resident-to-Resident Policy documented all incidents are to be documented in the resident's medical record with intense monitoring to continue for at least 72 hours.</p> <p>1. A review of the admission Record revealed R2 was admitted to the facility on [DATE] with the following diagnoses that include but are not limited to dementia with other behavioral disturbance, type 2 diabetes mellitus with diabetic nephropathy, and depression.</p> <p>A review of the Minimum Data Set (MDS) Quarterly assessment for R2 dated 1/16/2025 revealed the resident had severely impaired cognitive skills, displayed behaviors continuously present for inattention and disorganized thinking, and required Partial/to substantial supervision assistance for Activities of Daily Living.</p> <p>2. A review of the admission Record revealed R101 was admitted to the facility on [DATE] with the following diagnosis: epilepsy, nontraumatic intracerebral hemorrhage, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) for R101, dated 9/27/2024, documented a Brief Mental Status Score (BIMS) of three.</p> <p>Review of a Nurse Note Progress Note dated 2/3/2025 documented, Resident R2. Wanders in and out of other resident's rooms throughout the night. Resident was redirected to room every time. Resident started cursing at staff while trying to redirect her back in her room.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a Nurse Practitioner (NP) Progress Note dated 1/31/2025 at 3:14 pm revealed the resident was being evaluated for aggressive behavior. The nurse reported that there was an incident last night where R2 pulled another resident (R101) out of her bed and caused her to fall on the floor.</p> <p>Review of a Nurse Note Progress Note dated 1/31/2025 revealed R2 in doorway of room [ROOM NUMBER] with clothing off and R101 noted on the floor. R2 began to swing and curse at staff. Refused to come out of (R101's doorway).</p> <p>Interview on 2/6/2025 at 6:22 am with Registered Nurse (RN) XXXX stated that she contacted the DON and the physician directly to ensure proper follow-up along with the Nurse Practitioner (NP) of the Medical Director (MD) for notification of the incident between R101 and R2.</p> <p>Interview on 2/6/2025 at 10:01 am with Social Worker (SW) QQQ on the west wing revealed that she received a call from R101's FM, who stated that the nurse called him at 5:00 am on January 31, 2025, to inform him that his mother had been pulled out of bed by another resident. R101's FM stated that he was concerned. SW QQQ stated a grievance has been filed on his behalf, and further investigation will be made. SW QQQ also noted that further investigation revealed that there were two CNAs, one LPN, and one RN on duty the night R101 was discovered lying face up on her back, unclothed. SW QQQ stated that the nurse reported the incident to the doctor, and residents FM, hospice, and DON were informed.</p> <p>Interview on 2/11/2025 at 11:17 am with the DON revealed that RN XXXX called her on 1/31/2025 about the incident between 5:00 am and 5:30 am. The DON stated that all negative behaviors should be documented, including wandering. The DON further revealed that no skin assessments were done on residents after the incident.</p> <p>Interview on 2/11/2025 at 11:17 am with the Administrator revealed that a thorough investigation was not done. It was also revealed that they will change how investigations are done by not allowing the social worker to complete them.</p> <p>In addition, although the DON was aware of the abuse incident on the day it occurred, she did not report it to the Administrator or start an investigation.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record review, and review of the facility policy titled Comprehensive Care Plan, the facility failed to develop and/or implement a comprehensive person-centered care plan for two of 18 residents (R) (R101 and R2). Specifically, the facility failed to develop a care plan related to abuse for R101 and a care plan related to abusive behaviors for R2.</p> <p>On February 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The Facility's Administrator, Director of Nursing (DON), Director of Clinical Operations, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on February 11, 2025, at 2:21 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on January 31, 2025.</p> <p>The IJ was ongoing at the time of exit on February 14, 2025.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled Comprehensive Care Plan revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.</p> <p>1. Review of R101's electronic medical record (EMR) revealed diagnoses including, but not limited to, dementia and muscle weakness.</p> <p>Review of R101's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status of 3 (indicating severe cognitive impairment).</p> <p>Review of R101's Progress Notes revealed an entry dated 1/31/2025 documented an incident in which R2 entered R101's room, pulled her out of bed, and disrobed her. R2 was found sitting beside R101.</p> <p>Review of R101's care plan revealed no implementation of an abuse care plan to ensure R101's safety from future occurrences of abuse.</p> <p>2. Review of R2's EMR revealed diagnoses including, but not limited to, dementia with behavior disturbances.</p> <p>Review of R2's admission MDS dated [DATE] revealed a BIMS of 3 (indicating severe cognitive impairment).</p> <p>Review of R2's care plan revealed no implementation of an abuse care plan to address R2's abusive behaviors or interventions for monitoring and ensuring other resident's safety.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/14/2025 at 12:30 pm, MDS Coordinator JJJ confirmed no abuse care plan for R101 and R2. She stated the omission of the care plan was an error by the MDS staff.</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, staff interviews, record review, and review of the facility's policy titled Behavioral Health Services, the facility failed to ensure one of 22 sampled residents (R) (R2) received necessary behavior health services to address significant worsening behaviors, including physical abuse to another resident (R101).</p> <p>On February 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The Facility's Administrator, Director of Nursing (DON), Director of Clinical Operations, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on February 11, 2025, at 2:21 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on January 31, 2025.</p> <p>The IJ was ongoing at the time of exit on February 14, 2025</p> <p>Findings included:</p> <p>A review of the Behavioral Health Service policy dated 4/1/2024 documented It is the policy of the facility to assist them in reaching and maintaining their higher level of mental and psychosocial functioning. 5. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. c. Monitor resident p. Assisting residents with access to therapies, such as psychotherapy, behavioral modification, cognitive therapy, and problem-solving therapy. q. Provide support with skills related to verbal de-escalation, coping skills, and stress management.</p> <p>A review of the Electronic Medical Record (EMR) revealed that R2 was admitted to the facility on [DATE] with a diagnosis of adjustment disorder with unspecified dementia with other behavioral disturbances and depression.</p> <p>A review of the Minimum Data Set (MDS) Quarterly assessment for R2 dated 1/16/2025 revealed the resident had BIMS indicating severely impaired cognitive skills, displayed behaviors continuously present for inattention and disorganized thinking, and required Partial/to substantial supervision assistance for Activities of Daily Living.</p> <p>A review of R2's comprehensive care plan initiated on 12/9/2024 revealed that R2 had behaviors related to depression and anxiety. Interventions included staff referring residents to psychiatric services.</p> <p>Record review of a Physician Assistant (PA) Progress Note dated 1/31/2025 at 3:15 pm documented R2 pulled R101 out of the bed and caused R101 fall.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a nurse Progress Note dated 1/31/2025 at 6:10 am documented R2 noted with clothes off in doorway of R101's room, R101 noted on the floor, R2 began to swing and curse at staff, refusing to come out of the R101 doorway.</p> <p>Record review of a nurse Progress Note dated 1/30/2025 at 4:39 am documented R2 up all night in and out of other residents' room, yelling and use of profanity and displaying, and aggressive, Haldol injection given intramuscular and resident unable to be redirected.</p> <p>Record review of a nurse Progress Note dated 1/25/2025 at 5:48 pm documented R2 was displaying aggressive and threatening behaviors towards her roommate. The roommate reported being afraid for life and was moved to another room.</p> <p>Record review of R2's nurse Progress Note dated 1/17/2025 at 10:17 am documented R2 as having increased anxiety/agitation, wandering into other residents' rooms and opening the doors, preventing staff from providing patient care to residents, and using profanity toward residents and staff. Redirection was unsuccessful after several attempts.</p> <p>The documentation revealed that there were no interventions put into place for behaviors or psychiatric services before the incident that occurred on 1/31/2025.</p> <p>Observation on 2/4/2025, 2/7/2025, 2/10/2025, and 2/11/2025, R2 was observed at random times unsupervised (with no one-to-one supervision that provided close body physical contact) and not within line of sight of staff (resident was either alone in her room or independently ambulating back and forth in the hallway) on the memory care unit. During observation, the assigned, licensed nursing staff sat at the nursing station charting, answering the phone, or administering medications. The CNAs were either off the hall or providing patient care in another resident's room.</p> <p>A review of the psychiatric consultant notes (telehealth visit by video) revealed that the R2 was not seen by psychiatric services until 2/10/2025 for the incident that occurred on 1/31/2025 in which the resident pulled R101 out of her bed and disrobed her. The primary reason for the visit was that R2 was being seen for pulling a hospice resident out of her bed. The Psychiatric Nurse Practitioner (NP) recommended that the resident be monitored for mood and behavior and documented accordingly.</p> <p>The survey team was unable to reach the psychiatric NP for an interview.</p> <p>During an interview on 2/6/2025 at 9:48 am, the Administrator and Director of Nursing (DON) confirmed that the resident did not receive one-to-one supervised monitoring on 1/31/2025 shortly after the incident occurred. The Administrator reported being unaware of the incident. She reported becoming knowledgeable of the incident on 2/5/2025. The Administrator reported at the time of the incident that she was new to her position and was unaware of the monitoring requirements and follow-up for psychiatric services. The DON reported being aware of the incident on 1/31/2025 but unaware of how residents should follow up with psychiatric services.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/6/2025 at 4:33 pm, the Physician Assistant (PA), PA A1, confirmed that she was unaware R2 had wandering behaviors and was physically aggressive towards other residents. She reported that, in her professional opinion, R2 should have been recommended for psychiatric services and follow-up medications to manage her behavior. The PA A1 reported that facility staff should have provided monitoring for any resident who had been observed becoming physically aggressive towards others to ensure resident safety and the safety of other residents.</p> <p>Interview on 2/11/2025 at 1:15 pm., with DON reporting being unaware that no extra staff was in place to provide one-to-one for R2. She stated that the staff did not inform her that the third person assigned to the resident was not in the memory care unit. The DON reported that she would follow up to ensure one-to-one supervision is provided.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, record reviews, and review of the job descriptions for Nursing Home Administrator and Director of Nursing (DON), facility Administration failed to ensure that all components of the facility's abuse prevention system were implemented in a thorough and timely manner to address allegations of physical abuse for two Residents (R) (R101 and R2), from a total sample of 22 residents.</p> <p>On February 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The Facility's Administrator, Director of Nursing (DON), Director of Clinical Operations, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on February 11, 2025, at 2:21 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on January 31, 2025.</p> <p>The IJ was ongoing at the time of exit on February 14, 2025</p> <p>Findings included:</p> <p>A review of the Administrator's job description revealed section major duties: Reports any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents to appropriate regulatory entities. Protects residents from abuse and cooperates with all investigations. Treats all residents with dignity and respect. Section additional task: Promotes and protects all residents' rights. Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etc. are reported to the correct entity within the stated regulatory requirement.</p> <p>A review of the DON's job description revealed section major duties- oversees resident incidents and concerns daily to identify any unusual occurrences and reports them promptly to the Administrator and/or state agency for appropriate action, monitors for allegations of potential abuse or neglect, or misappropriation of resident property and participates in the investigative process. Section Additional task: Reports any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents to supervisor and/or administrator. Protects residents from abuse and cooperates with all investigations.</p> <p>The Administration failed to demonstrate competency consistently and effectively in protecting and promoting residents' rights to be free from abuse, which is included in the Administrator and DON's job description.</p> <p>1. The Administration failed to maintain an environment free from abuse for one resident, R101, perpetuated by R2.</p> <p>Cross reference to F600.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. The Administration failed to ensure that incidents of abuse for one resident R101 perpetuated by R2 was reported in a timely manner to required agencies.</p> <p>Cross reference to F609.</p> <p>3. The Administration failed to ensure that incidents of abuse for one resident R101 perpetuated by R2 was thoroughly investigated, and corrective actions implemented, including protection of the resident, in a timely manner.</p> <p>Cross reference to F610.</p> <p>4. The facility failed to create a care plan for abuse for R101 and R2 related to physical abuse occurring on 1/31/2025.</p> <p>Cross reference to F656.</p> <p>Review of a Nurse Practitioner (NP) Progress Note dated 1/31/2025 at 3:14 pm revealed the resident was being evaluated for aggressive behavior. The nurse reported that there was an incident last night where R2 pulled another resident (R101) out of her bed and caused her to fall on the floor.</p> <p>Review of a Nurse Note Progress Note dated 1/31/2025 revealed R2 in the doorway of room [ROOM NUMBER] with clothing off and resident (R101) noted on the floor. The resident (R2) began to swing and curse at the staff. Refused to come out of resident's (R101) doorway.</p> <p>Interview on 2/6/2025 at 6:22 am with Registered Nurse (RN) XXXX recalled the incident that happened on 1/31/2025 between R101 and R2. She revealed that she entered the memory care unit during rounds and spoke with the LPN on duty. She informed me that an incident had occurred earlier, at about 4:00 or 4:30 am. According to the LPN, the resident in room [ROOM NUMBER] A (R2), after removing her clothes, pulled the resident in room [ROOM NUMBER]A (R101) to the floor. She also reported that the resident (R2) was not wearing any clothes during the incident. RN XXXX stated that she contacted the DON and physician directly to ensure proper follow-up. RN XXXX confirmed speaking with the NP of the Medical Director (MD), hospice, and the family member (FM) of R101.</p> <p>Phone interview on 2/6/2025 at 11:37 am with (LPN) YYYY recalled the incident that happened during her night shift beginning on 1/30/2025 but occurred early morning on 1/31/2025 between R101 and R2; she was called to the resident (R101) room by a CNA. LPN YYYY stated that R101 was lying on her back and buttocks on the floor. No injury was noted. She notified the physician of the incident. LPN YYYY revealed that R2 was in the resident's (R101) doorway with their clothing off. LPN YYYY stated she called hospice and R101's FM and notified him. She revealed that the supervisor was made aware of the situation.</p> <p>Interview on 2/11/2025 at 11:17 am with the DON revealed that RN XXXX called her about the incident between 5:00 am and 5:30 am. The DON stated that wandering and all negative behaviors should be documented; however, she was unaware that R2 was wandering. The DON stated that no skin assessments were performed on residents after the incident. The DON revealed that she did not report the incident.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 2/11/2025 at 11:17 am with the Administrator revealed that a thorough investigation had not been done and that the report was not submitted on time. The Administrator stated that the facility will change how investigations are done by not allowing the social worker to complete them. The Administrator confirmed that she is the Abuse Coordinator and was unaware of the allegations of abuse. The Administrator revealed that if she had known of the abuse, she would have reported it immediately.</p>		