STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115624	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thunderbolt Care Center LLC	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)
F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, interviews, and review of the policy titled Care Plan Policy, the facility failed to update and revise the comprehensive person-centered care plan related to unwitnessed falls for two of four residents (R) (R12 and R14) after falls with major injury. Actual harm occurred on 4/7/2025 when R12 fell out of bed, resulting in a laceration to the head, closed traumatic right eye injury, right humerus (shoulder) fracture, and right femoral (leg) fracture. Additionally, harm occurred on 2/27/2025 when R14 was found on the floor, resulting in a subdural hematoma measuring up to 3 mm (millimeters), traumatic subarachnoid hemorrhage, hypotension, left forehead laceration 1.18 inches complex laceration requiring alignment of multiple irregular edges, some debridement, and left cheek laceration 1.18 inches. Findings include: Review of the policy titled Comprehensive Care Plans, implemented 4/1/2024, section; Policy revealed the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 1. Review of the Electronic Medical Record (EMR) revealed R12 had a diagnoses including but not limited to fall on same level, unspecified, subsequent encounter, muscle weakness (generalized), unspecified lack of coordination, need for assistance with personal care, unspecified fall, initial encounter, multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of the most recent care plan revised on 11/7/2024 for R12, revealed a focus area that R12 has the potential for falls related to a history of prior falls. Interventions included: Resident has cognitive deficits-encourage monitoring, educate resident/ family/caregivers about safety reminders and what to do if a fall occurs, encourage socialization and activity attendance as tolerated, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, fall risk screening upon admission and quarterly to identify risk factors, place the resident's call light within reach and encourage the resident to use it for assistance as needed. A review of the progress notes dated 4/7/2025 at 7:06 pm revealed that the Licensed Practical Nurse (LPN) HH was in R12's room to administer medication, and R12 attempted to get out of bed. The LPN HH assisted R12 back to bed and administered medication. A continuation of the same progress notes further revealed that this LPN HH left the room to finish the medication pass, and another staff member walking down the hall found R12 on the floor going toward the door of her room. R12 explained to the staff member that she had gotten out of bed and fallen. R12 was assessed and injuries were found to the right elbow, swollen right shoulder, swollen right jaw, broken blood vessel in right eye, right arm pain on movement and touch, and right neck and jaw pain. R12 was sent to the local hospital at 6:11 pm. 2. Review of the EMR revealed R14 was admitted to the facility with a diagnosis including, but not limited to muscle weakness (generalized), other lack of coordination, fall on same level, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance. A review of the nost recent care plan revised on 5/23/2024 for R14 revealed a focus area that R14 is at risk for falls related to poor balance, unsteady gait, and is at risk for further falls. Listed falls: 1/9/2023 fall, 1/16/2023 fall, 1/20/2023 fall, 5/23/2023 fall, 7/22/2023 fall, 12/17/2023 fall, 2/17/2024 fall, 2/20/2024 fall, 6/3/2024 fall, 6/24/2024 fall, 8/7/2024 fall, Interventions revised on 8/7/2024 revealed re-educated on the use of call light system to obtain assistance for transfers and other ADLS, as needed, for no apparent acute injury determine and address causative factors for the fall, staff will continue to assist and assess for slippery clothing, fall evaluation related to increase confusion. A review of the progress notes dated 2/24/2025 at 6:47 pm revealed R14 was found on the floor lying on her stomach with her left arm behind her, bleeding from the head. The resident was sent to the hospital. Interview on 5/16/2025 at 3:04 pm with Minimum Data Set Coordinator (MDS), MDS LL revealed she has been working with MDS since December. MDS LL stated she cross references to ensure all identified areas of concern are added to the care plan as needed. However, the social workers add all identified areas of concern to the care plan. MDS stated she completes monthly care plan audits. Interview on 5/16/2025 at 3:09 pm with Social Worker (SW) II stated that residents' areas of concern should be included in the care plan. SW II stated she works with the MDS and addresses concerns in the morning meeting. SW II revealed that she completes weekly audits to identify concerns. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Interview on 5/22/2025 at 5:30 pm with MDS B revealed that the facility manages both Medicare and Medicaid cases. She stated that a significant change is identified when a resident declines in two or more areas, such as ADLs, weight loss, or hospice eligibility, and they have 14 days to complete the change. MDS B revealed that if a resident falls and returns with a fracture, they are expected to have functional changes, such as limited ambulation. She stated that residents in therapy are given the opportunity to participate and regain mobility before their status is reassessed. She further revealed that when a resident exhibits both ADL decline and cognitive decline, it may require a significant change in reassessment, and that resident assessments are conducted quarterly to monitor ongoing changes.

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(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 - 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 observation, interviews, record review, and review of the facility policy titled Accidents and Supervision, the facility failed to ensure adequate supervision, re-assess residents for fall risk, and update care plans based on repeated falls for two of four residents (R) (R12 and R14) reviewed for accidents. Actual harm occurred on 4/7/2025 when R12 fell out of bed, resulting in a laceration to the head, closed traumatic right eye injury, right humerus (shoulder) fracture, and right femoral (leg) fracture. Additionally, harm occurred on 2/27/2025 when R14 was found on the floor, resulting in a subdural hematoma measuring up to 3 mm (millimeters), traumatic subarachnoid hemorrhage, hypotension, left forehead laceration 1.18 inches complex laceration requiring alignment of multiple irregular edges, some debridement, and left cheek laceration 1.18 inches. Findings include: A review of the policy titled Accidents and Supervision revision date 10/18/2024 revealed the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he/she had caught him/herself, is considered a fall. A fall with injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Supervision/Adequate Supervision refers to intervention and means of mitigating the risk of an accident. 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. b. Both the facility-centered and resident-directed approaches include evaluating and assessing accident risk and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, locations, etc. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff, e. Ensuring that the interventions are put into action, e.g., the Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully. i. Resident-directed approaches may include: i. implementing specific interventions as part of the plan of care, iii. Facility records document the implementation of these interventions. 4. Monitoring and Modification- Monitoring the process of evaluating the effectiveness of care plan interventions. Monitoring and modification process include: a. Ensuring that interventions are implemented correctly and consistently, b. Evaluating the effectiveness of interventions, c. Modifying or replacing interventions as needed, d. Evaluating the effectiveness of new interventions. Supervision- b. Based on the individual resident's assessed needs and identified hazards in the resident environment. 1.Review of the Electronic Medical Record (EMR) revealed R12 had a diagnoses including but not limited to fall on same level, unspecified, subsequent encounter, muscle weakness (generalized), unspecified lack of coordination, need for assistance with personal care, unspecified fall, initial encounter, multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R12 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12, indicating R12 had moderate cognitive impairment. Section GG, functional status, revealed R12 uses a wheelchair and requires assistance with lower and upper body dressing. R12 has a history of four unwitnessed falls over the last five months, with the most recent fall with actual harm on 4/7/2025. A review of the Fall Risk Assessment for R12 dated 10/16/2024 revealed a risk score of 10 or over, indicating a high risk. There were no other risk assessments documented for R12. Further review of the medical record revealed documentation of one Interdisciplinary Team (IDT) discussion on 11/7/2024 that revealed R12 was observed sitting on the floor of her room. Intervention: increase staff monitoring. A review of the Electronic Medical Record (EMR) revealed no evidence of documentation of increased staff monitoring. A review of the Post Fall Assessment dated 11/7/2024 revealed the document was not completed, 2/19/2025 reminded to use the call light, 2/28/2025 reminders to call for assistance. A review of the Neurological Assessments dated 11/7/2024 revealed completed on 11/7/2024 at 10:03 pm, 2/19/2025 was not completed, 2/27/2025 was partially completed for the three-hour status post incident, and 2/28/2025 was partially completed for the eight-hour status post incident. A review of the progress notes dated 4/7/2025 at 7:06 pm revealed that the Licensed Practical Nurse (LPN) HH was in R12's room to administer medication, and R12 attempted to get out of bed. The LPN HH assisted R12 back to bed and administered medication. A continuation of the same progress notes further revealed that this LPN HH left the room to finish the medication pass, and another staff member walking down the hall found R12 on the floor going toward the door of her room. R12 explained to the staff member that she had gotten out of bed and fallen. R12 was assessed and injuries were found to the right elbow, swollen right shoulder, swollen right jaw, broken blood vessel in right eye, right arm pain on movement and touch, and right neck and jaw pain. R12 was sent to the local hospital on 4/7/2025 at 6:11 pm. A review of the Interdisciplinary Team (IDT) note dated 4/8/2025 at 11:05 am revealed R12 had a fall on 4/7/2025 with injuries. R12 stated she was getting out of bed but didn't remember why, and she has a history of falls. Intervention: scoop mattress. A review of the hospital records revealed an admission date of 4/7/2025, revealing R12 had an unwitnessed fall. R12 had a diagnosis of the right humerus fracture, closed traumatic eye injury, right femoral fracture, and maxillary fractures. No surgery was required, and the resident was discharged on 4/10/2025. A review of the discharge instructions dated 4/10/2025 was to follow up with an Ophthalmologist. Confirmed with the interim DON, this follow up did not occur. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 05/22/2025 at 10:15 am revealed R12 to be alert but not oriented, confused, and mumbled when speaking. The resident appeared frail with facial swelling. The bed is at the lowest position and has no fall mat. Call light on the bed. Observed a family member handing R12 the call light to R12, asking her to press the light. R12 was unable to press the call light button independently without being prompted by family. 2. Review of the EMR revealed R14 was admitted to the facility with a diagnosis including, but not limited to muscle weakness (generalized), other lack of coordination, fall on same level, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance. Review of the quarterly MDS assessment for R14 dated 2/18/2025, revealed a BIMS of 6, indicating severe cognitive impairment. Section GG, functional status, revealed R14 uses a wheelchair and requires partial /moderate assistance with Activities of Daily Living (ADLs.) R14 has a history of multiple falls with injuries in the facility. In 2023 - six falls, 2024 - four falls, with the most recent on 2/24/2025 where actual harm occurred. A review of the Fall Risk Assessment for R14 dated 1/20/2023 revealed a risk score of 19 or over, indicating a high risk. There were no other risk assessments documented for R14 after 1/20/2023. A review of Post Fall Assessment dated 6/5/2024 revealed that staff to assist resident with dressing, and check to see if clothing is slippery, 6/24/2024 educated resident to call staff for assistance, 8/7/2024 resident encourage to use call system for any assistance to reduce risk of falls or further injury, 2/24/2024 offer to take resident to the bathroom every two hours. A review of Neurological Assessment dated 6/3/2024 revealed the document was not completed, 8/7/2024 was only partially completed for the 20, 28, 36, and 60 hour status post incident, 2/24/2025 was only partially completed for the one hour status post incident. A review of the progress notes dated 2/24/2025 at 6:47 pm revealed R14 was found on the floor lying on her stomach with her left arm behind her, bleeding from the head. The resident was sent to the hospital. A review of the hospital records dated 2/24/2025 revealed R14 was admitted to the intensive care unit (ICU) for blood pressure stabilization and head injury. R14 had a diagnosis of subdural hematoma, traumatic subarachnoid hemorrhage, hypotension, left forehead laceration 1.18 inches complex laceration requiring alignment of multiple irregular edges, some debridement, and left cheek laceration 1.18 inches. No surgery was required, and the resident was discharged back to the facility on 2/27/2025. There was no documented evidence that the IDT had met or revised the plan in response to the changes in fall frequency. Observations on 5/23 /2025 at 11:55 am of R14's room revealed that the bed was at the lowest level, but no fall mats were present. R14 was observed sitting in the activity room, with a bump on her forehead and a bandage on the left side of her face. R14 had dried blood off the top and bottom of the bandage on her face. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 5/23/2025 at 12:15 pm with Licensed Practical Nurse (LPN) N revealed she was unaware of when or how R14 developed the facial bruise. She documented an observation of a wound on R14's upper left cheek. LPN N stated that R14 moves freely around the facility in her wheelchair and was in the East Wing when she noticed the wound. LPN N revealed later that she had inquired, and the bump on R14's forehead was attributed to her February fall. Interview on 5/16/2025 at 3:04 pm with Minimum Data Set Coordinator (MDS), MDS LL revealed she has been working with MDS since December. MDS LL stated she cross references to ensure all identified areas of concern are added to the care plan as needed. However, the social workers add all identified areas of concern to the care plan. MDS stated she completes monthly care plan audits. Interview on 5/23/3035 at 2:50 pm with the Interim DON revealed that all residents are considered at risk for falls due to various factors, including environmental changes, medications, diagnoses, and functional limitations. The DON further revealed that the facility tracks residents with a history of falls and those at risk, based on potential and past occurrences of falls. She stated that falls are documented through an event report and a post-fall review assessment, and neurological assessments are conducted for unwitnessed falls or head injuries. The DON stated that the standard assessment intervals include checks every 15 minutes, initially, then gradually extending to longer periods over hours. The DON confirmed that R12 and R14 did have a fall with major injuries. Interview on 5/23/2025 at 3:22 pm with the Medical Director (MD) revealed that neurological checks should be conducted as soon as staff are aware that a fall has occurred, especially for unwitnessed falls or head injuries. He further revealed that medications are typically reviewed if falls occur frequently, rather than a single event, and physical therapy often conducts evaluations to assess mobility and risk factors. At this time, he did not recall if R12 and R14 had a medication review related to falls. The MD revealed that staff are expected to implement preventive strategies to help reduce future falls. He stated that position change alarms are not commonly used, as they could be considered a form of restraint. The MD stated that a Performance Improvement Plan (PIP) discussion may be initiated to explore alternative preventive measures for residents experiencing multiple falls. The facility had no documented evidence that the care plans were re-assessed and new intervetions put into place related to the numerous falls for both residents.