

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Tybee Island Trails of Journey LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 26 Van Horne Street Tybee Island, GA 31328	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, the facility failed to report injuries of unknown origin to the State Survey Agency (SSA) within the required time frame for one of three sampled residents (R) (R6) reviewed for abuse and neglect. The deficient practice had the potential for future unreported injuries of unknown origin, with the potential to affect residents' quality of life. Findings include: Review of the policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation last reviewed February 13, 2024, documented under Compliance Guidelines: 8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: 2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. Review of the electronic medical record (EMR) revealed R6 was admitted to the facility with diagnoses including but not limited to schizoaffective disorder, unspecified, generalized anxiety disorder, type 1 diabetes mellitus with ketoacidosis without coma, chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery without angina pectoris. Record review of R6's admission Minimum Data Set (MDS) dated [DATE] assessed for Section C (Cognitive Patterns) a Brief Interview Mental Status Score (BIMS) of two, which indicated severe cognitive impairments. Section G (Functional Abilities) assessed non-ambulatory, no impairments for upper/lower extremities, dependent- maximum substantial assistance with most Activities of Daily Living Skills (ADL). Record review of R6's (nursing home facility) EMR Interdisciplinary Team (IDT) progress note (dated 05/28/2026 at 3:06 PM documented a fall incident. The note stated, Clearing Risk Management. IDT Meeting: Resident with unwitnessed fall in room while attempting self-transfer 05/07/2026. No injury. Action: NP (Nurse Practitioner) notified. Root Cause: Encephalopathy, anxiety, and chronic pain. Intervention: Place bed in the lowest position and add fall mat. Record review of R6's [name] nursing home facility EMR's progress note dated 05/21/2026 at 10:18 AM documented by the Primary Health Mental Health Nurse Practitioner (PMHNP) and noted by Nurse Practitioner NP (dated 05/28/2026 at 0:00 PM) stated They also report intermittent self-injury behaviors, including intentionally throwing herself from her wheelchair onto the floor, engaging in self-induced vomiting. This behavior appears impulsive and often triggered by internal distress, frustration, and a perceived lack of attention. The staff notes that the patient (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 115633	Facility ID: 115633 If continuation sheet Page 1 of 2

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sometimes threatens to throw herself on the floor and has followed through on these threats without regard to her safety. Record review of R6's [name] hospital ER (Emergency Room) documented the chief complaint for ER visit as R6 was transferred from nursing home due to chief complaint of generalized weakness and pain. Record review of R6's [name] hospital ER physician's progress notes dated 05/30/2026 reported a fracture of ribs (3-6) (two-three) and pubic rami fracture (pelvic). Further review of the physician's progress note stated: Patient is the resident of [name] facility. Concern for neglect; multiple previous hospitalizations with DKA(Diabetic Ketoacidosis). Noted to have multiple new fractures during this hospitalization. Record review of [name] nursing home facility Licensed Practical Nurse (LPN) LPN EE EMR notes dated 06/08/2026 at 7:19 PM, documented resident returned via (by) ambulance on a stretcher. Arrived about 3:00 o' clock. VSS (vital signs) 117/65 82 18 98.2. pleasant. Treated at hospital for UTI (urinary tract infection); returned on ABX (antibiotic). 3 FX. (three fractures) Resident is able to make needs known. Record review of the [name] nursing home facility's Physician Assistant (PA) PA BB EMR progress note dated 06/09/2026 at 10:45 and 06/11/2026 at 4:36 PM documented R6 readmitted to the facility on [DATE] for rehabilitation following recent hospitalization at {named} Health was admitted with generalized weakness, pain, UTI (urinary tract infection), recurrent hypoglycemia, and multiple acute fractures (left lateral ribs 3-6 (three -six), right acetabular fracture, bilateral inferior pubic rami). R6 was also noted with a left frontal peritoneal hematoma. Record review of R6's care plan created 06/11/2026 listed a problem focus area of multiple fractures. Interview on 07/28/2026 at 2:00 PM with the Administrator revealed that she was unaware that R6 was noted to have injuries related to a fractured pelvis and ribs after her return from the hospital. She reported being aware that prior to hospitalization, the resident was exhibiting behaviors of throwing herself on the floor from her bed. She reported that if she had been made aware, she would have reported it to the State Office. Interview on 07/28/2026 at 2:45 PM with the Director of Nursing (DON) revealed being aware of the fractures once the R6 returned to the hospital on [DATE]. DON reported reading the hospital record and failing to discuss it with the Administrator and other staff. She reported being aware that prior to hospitalization, the resident was exhibiting behaviors of throwing herself on the floor from her bed. She confirmed not reporting R6 ?s injuries related to a fall to the State Office within the 24-hour time frame. Interview on 07/29/2026 at 2:01 PM, [name], Rehab Therapy Director, CC confirmed being knowledgeable of R6's fractured ribs and pelvis after R6 returned to the facility on [DATE]. This information was provided to her in R6's discharged hospital record. Therapy Director reported that her findings were discussed immediately with certified nursing assistant (CNA) AA and with an unknown nurse. Interview on 07/29/2026 at 10:10 AM with Certified Nursing Assistant (CNA) AA. CNA AA reported that R6 was known to be very confused, throw herself out of bed, and fall violently on the floor. She had a history of attempting to get out of bed without assistance and being found on the floor on several occasions. R6 was unable to ambulate without assistance and required supervision. CNA AA reported working on the day of 05/30/2026 (the day R6 fell out of bed). She reported entering R6's room, observing R6 on the floor by her bed. She recalled R6 moaning and groaning. She did not recall witnessing any bruises because she immediately summoned the nurse. The nurse on duty sent the resident to the hospital.		