STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115633	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tybee Island Care Center LLC	26 Van Horne Street Tybee Island, GA 31328

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37739 Based on observations, staff interviews, and review of the facility policy titled Promoting/Maintaining Resident Dignity During Mealtimes, the facility failed to promote dignity during dining for four of 36 sampled residents (R) (R16, R45, R42, and R250) related to staff referring to residents as feeders and not serving resident meals at the same time for residents who were dining together. These failures had the potential to diminish the resident's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings included: A review of the facility's undated policy titled Promoting/Maintaining Resident Dignity During Mealtimes, revealed the Policy of It is the practice of the facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. The Policy Explanation and Compliance Guidelines section included 1. All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes. During a breakfast dining observation on 10/28/2024 at 8:00 am, the staff was observed passing out meal trays in the main dining room to approximately 32 residents. Certified Nursing Assistant (CNA) EE came into the dining room and was told by CNA GG that all the trays had not arrived. CNA EE confirmed that 11 residents did not have meal trays, including the dependent residents. CNA GG stated loudly, The feeder's trays ain't [sic] here? She was observed to reference the dependent residents as feeders multiple times during the meal observation in the direct area of the dependent residents (R16, R45, and R42). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a breakfast dining observation on 10/28/2024 at 8:00 am, four residents (R250, R8, R41, and R17) were observed sitting at the table together awaiting their meals. Three of the four residents (R8, R41, and R17) were served at 8:00 am. R250 was not served a tray and was observed watching the other three residents eat. During an interview with R250 at 8:10 am, he was asked if he was ready for breakfast, and he stated he wanted coffee and breakfast. During this observation, R17 finished breakfast and left the dining room at 8:15 am, and R8 finished his meal at 8:19 am and left the table. R41 stayed at the table with R250. She motioned for the Director of Nursing (DON) to come to the table at 8:26 am and stated that R250 had not received a breakfast tray. The DON asked Licensed Practical Nurse (LPN) HH if there was a tray for R250. LPN HH stated, What? He didn't eat? The DON said to R250, We got you a tray coming. Thank you (R41) for letting me know. R250's received a meal tray at 8:28 am. During an interview with LPN HH on 10/28/2024 at 8:31 am, she stated R250 was new to her, and she did not know he had not eaten until the DON informed her. She stated she would fill out a diet slip just in case they didn't have one. During an interview on 10/28/2024 at 10:49 am, CNA EE stated that she had received in-services related to dining, and stated All residents at the same table should be served at the same time. She explained that the situation with R250 not getting a tray was because he was new and must have come in over the weekend, so LPN HH had to go to the kitchen to get his tray. She was asked about the dependent residents and stated, Feeders come in last. We like to get the feeders out of bed. The feeders sit at the round table. She was asked if any of the dependent residents were alert, and she confirmed that R45 and R42 were alert. She was asked if she had received education related to labeling residents as feeders being a dignity concern, and she stated that she had always called them feeders. During an interview on 10/28/2024 at 11:00 am, LPN HH stated that she had not noticed if the staff referred to dependent residents as feeders, but if they had, that would be a dignity concern, especially if they were doing so in front of the residents. She stated if she was made aware of this or observed this behavior, she would pull the staff to the side and correct them. She confirmed that R45 and R42 were alert, dependent on staff for dining assistance, and sat in the dining room at the round table with R16.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37739 Based on staff interviews, record review, and a review of the facility policy titled Residents' Rights and Treatment Regarding Advance Directives, the facility failed to ensure there were no discrepancies related to Advanced Directives for one of 38 sampled residents (R) (R3). The deficient practice had the potential to result in R3's Advance Directives not being followed. Findings included: A review of the facility policy titled Residents' Rights and Treatment Regarding Advance Directives, dated [DATE], revealed that it is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. Decisions regarding advanced directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions, and whether the resident wishes to change these instructions. Any decision-making regarding the resident's choice will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. A review of the Electronic Medical Record (EMR) for R3 revealed an admitted [DATE]. A review of the care plan, last updated on [DATE], revealed that R3 had an advanced directive for Do Not Resuscitate (DNR) and that the resident DNR wishes wound be followed by staff through the next review. In the event that R3's heart stops beating, the facility staff were instructed not to perform Cardiopulmonary Resuscitation (CPR). It was noted that the facility would maintain the DNR form under Advance Directives in the resident's medical record. A review of the EMR revealed that R3 was documented as being a Full Code. However, a review of the physical medical chart revealed that R3 had a Physician Orders for Life-Sustaining Treatment (POLST) Georgia form dated [DATE] noting an order for DNR and a POLST Georgia form dated [DATE] noting an order for full code. During an interview on [DATE] at 9:40 am, Registered Nurse (RN) KK confirmed that the facility used a hybrid system of the EMR and the physical medical record. RN KK stated that she would use the EMR to identify the code status of a resident who was found unresponsive. She confirmed that the EMR noted that R3 was full code and that she would provide resuscitation efforts if R3 was found unresponsive. She was asked about the POLST Georgia form dated [DATE] noting an order for DNR in the physical record and she acknowledged that this was a discrepancy and needed to be reviewed. During an interview on [DATE] at 9:48 am, the Minimum Data Set (MDS) Coordinator stated that the POLST Georgia form dated [DATE], noting that R3 had an active order for full code, should have been removed due to the date. She stated that the nurse should have put the order in the EMR when the new POLST Form was signed by the physician. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:09 am, the Director of Nursing (DON) stated that the nurses are supposed to look at the EMR to determine resident code status. She was asked to verify R3's status. She stated that he was full code and that they would start CPR if he was found unresponsive. During an interview on [DATE] at 10:12 am, the Administrator stated there was a discrepancy in the EMR and the physical medical record for R3. She confirmed that she was the acting Social Worker and that it was between her and the DON to ensure that the EMR was updated. She confirmed that R3's current code status was DNR.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37739 Based on observations and staff interviews, the facility failed to ensure a clean, comfortable, and homelike environment for nine of 26 resident rooms (Rooms 15, 10, 11, 18, 20, 7, 16, 17, and 9) and one of two shower rooms (Ladies' Shower Room). These deficient practices had the potential to place the residents residing in and using the rooms at risk of living in an unsanitary and unsafe living environment and a potential for diminished quality of life. Findings included: During a resident room observation in room [ROOM NUMBER] on 10/26/2024 at 8:04 am, the following was observed: unlabeled and unbagged personal care products (skin and hair cleanser), unbagged and unclean graduate sitting on the back of the toilet, the paper towel dispenser was empty, the toilet was dirty, and the hand sanitizer dispenser was not working. A resident room observation in room [ROOM NUMBER] on 10/26/2024 at 9:19 am revealed thin linen sheets with stains, stains on the privacy curtain by Bed A, and writing on the walls by Bed A. A resident room observation in room [ROOM NUMBER] on 10/26/2024 at 10:36 am revealed a small indenture behind the door, missing paint from the door, rust on the vent in the room, faded spots in the privacy curtain, and there was no pull string for the overbed light. A resident room observation in room [ROOM NUMBER] on 10/26/2024 at 10:36 am revealed the floor tile was dirty and stained, broken window blinds, rust, dirt, and chipped paint in the room near the air unit, and the air unit was not sealed (the outside light was visible from the unit). An observation of the shared bathroom for rooms [ROOM NUMBERS] revealed the following: an empty soap dispenser, the floor vinyl peeling up, and plastic molding detaching from the wall. A resident room observation in room [ROOM NUMBER] on 10/26/2024 at 11:20 am revealed a broken toilet with the toilet tank cover sitting on the floor behind the toilet. The toilet flushing mechanism was observed to stick and continue to run when flushed. The sink was caked with a white and green thick build-up. There were unlabeled and unbagged personal care products (skin and hair cleanser), the floor vinyl peeling up, and the plastic molding was detaching from the wall. A resident room observation in room [ROOM NUMBER] on 10/26/2024 at 2:11 pm revealed a short privacy curtain between Bed A and Bed B. An observation in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER] on 10/26/2024 at 9:45 am revealed the sink was dirty with hair, there were no paper towels in the dispenser, the toilet seat was observed with a dried brown substance on it, and hair was on the toilet. A resident room observation in room [ROOM NUMBER] on 10/27/2024 at 8:55 am revealed a strong urine smell in the room, missing paint from the wall, and short privacy curtains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A resident room observation in room [ROOM NUMBER] on 10/27/2024 at 8:58 am revealed a stained/bleached-out privacy curtain near Bed A. On 10/27/2024 at 4:30 pm, the Ladies' Shower Room was observed with a rusty chair and a black substance on the mesh shower chair. During an interview on 10/27/2024 at 4:26 pm, Housekeeper NN confirmed there was a strong urine smell in room [ROOM NUMBER] and stated it was a normal nursing home scent. She was unable to tell how often rooms were deep cleaned. During a comprehensive tour of the facility with the Administrator and the Regional Director of Environmental Services (RDES) on 10/28/2024 at 11:56 am, they confirmed all the areas of concern. The RDES stated that he visits the building twice a month.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35180 Based on staff interviews, record review, and review of the facility policy titled Comprehensive Care Plans, the facility failed to develop or implement comprehensive person-centered care plans for eight of 38 sampled residents (R) (R39, R42, R8, R19, R3, R10, R13, and R22). This failure increased the potential for R39, R42, R8, R19, R3, R10, R13, and R22 to not receive treatment and/or care according to their needs. Findings include: A review of the facility's undated policy titled Comprehensive Care Plans, revealed the care planning process would include an assessment of the resident's strengths and needs. The comprehensive care plan would be developed within seven days after completion of the comprehensive Minimum Data Set (MDS) assessment, and all Care Assessment Areas (CAAs) triggered by the MDS would be considered in developing the plan of care. Other factors would be determined by the interdisciplinary team (IDT) or as evidenced by the resident's clinical record. 1. A review of R39's medical record revealed diagnoses including dementia, weakness and unsteadiness on his feet, cognitive communication deficit, sexual dysfunction, and hypertension. A review of R39's MDS OBRA Annual Assessment, dated 2/14/2024, Section V (Care Assessment Area [CAA] Summary), revealed the assessment triggered cognitive loss/dementia, communication, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence, psychosocial wellbeing, behavioral symptoms, and pressure ulcer. A review of R39's medical record revealed physician's orders dated 2/8/2024 for amlodipine besylate, 5 milligrams (mg) one tablet by mouth (PO) one time a day (QD) for hypertension, 9/27/2024 Abilify 2 mg PO QD for dementia with behavioral disturbances, and 2/22/2024 Provera 5 mg PO QD morning for hypersexuality. A review of R39's care plan revealed that it did not include a plan for dementia, communication, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well-being, behavioral symptoms, risk for pressure ulcer, and hypertension. 2. A review of R42's medical record revealed diagnoses including dementia, cognitive communication deficit, hypertension, gastroesophageal reflux disease (GERD), hyperlipidemia, and major depressive disorder. A review of R42's MDS OBRA Admission Assessment, dated 2/26/2024, Section V (CAA Summary), revealed the assessment triggered cognitive loss/dementia, communication, urinary incontinence, behavioral symptoms, pressure ulcer, and psychotropic drug use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R42's medical record revealed physician's orders dated 3/13/2024 for lorazepam 1 mg PO three times a day (TID) for anxiety, 3/8/2024 trazodone hydrochloride (HCL) tablet 25 mg PO at bedtime (HS) for insomnia, 2/15/2024 amlodipine besylate 10 mg PO QD for hypertension, 2/15/2024 rosuvastatin calcium 10 mg PO QD for lipid control (hyperlipidemia), 2/15/2024 pantoprazole sodium 40 mg PO QD for GERD, 2/15/2024 quetiapine fumarate oral 50 mg PO QD for manic disorder, 2/14/2024 olanzapine 5 mg PO two times (BID) a day for manic disorder, and 2/14/2024 losartan potassium 50 mg PO BID for hypertension. A review of R42's care plan revealed the care plan did not include a plan for cognitive loss/dementia, communication, urinary incontinence, behavioral symptoms, pressure ulcer risk, psychotropic drug use, hypertension, anxiety, antipsychotic drug use, insomnia, GERD, hyperlipidemia, and manic disorder. 3. A review of R8's medical record revealed diagnoses including atrial fibrillation, chronic obstructive pulmonary disease (COPD), seizures, cerebral infarction, insomnia, hyperlipidemia, GERD, hypertension, and mental disorder. A review of R8's MDS OBRA Admission Assessment, dated 9/9/2024, Section V (CAA) Summary, revealed the assessment triggered cognitive loss/dementia, communication, and dental care. A review of R8's medical record revealed physician's orders dated 10/17/2024 for olanzapine 5 mg PO TID for psychosis, 10/11/2024 Depakote 250 mg PO BID for dementia with behavioral disturbances, 8/30/2024 hydrocodone-acetaminophen 5-325 mg PO every 6 hours as needed for pain, 8/28/2024 Trelegy Ellipta inhalation aerosol 100-62.5-25 micrograms (MCG)/actuation (ACT) one puff via oral inhalation in the morning for COPD, 8/28/2024 donepezil HCl 5 mg PO at HS for dementia, 8/28/2024 atorvastatin calcium 20 mg at PO HS for hyperlipidemia, 8/28/2024 levetiracetam 1000 mg PO BID for seizures, 8/29/2024 diltiazem 120 mg PO in the morning for hypertension, 8/28/2024 metoprolol tartrate 25 mg give 0.5 tablet PO BID for hypertension, and 8/28/2024 pantoprazole sodium 40 mg, PO QD for GERD. A review of R8's care plan revealed the care plan did not include a plan for dementia, communication, dental care, antipsychotic drug use, pain, narcotic use, COPD, hyperlipidemia, seizures, hypertension, GERD, atrial fibrillation, cerebral infarction, mental disorder, and insomnia. 4. A review of R19's medical record revealed diagnoses of hyperlipidemia and GERD. A review of R19's medical record revealed physician's orders dated 8/16/2021 for omeprazole 40 mg PO QD for GERD and 8/16/2021 atorvastatin 20 mg PO QD for hyperlipidemia. A review of R19's care plan revealed that it did not include a plan for hyperlipidemia and GERD. During an interview with the MDS Coordinator on 10/27/2024 at 3:30 pm, the MDS Coordinator acknowledged that the MDS assessment triggered areas in R39, R42, and R8's CCA Summary that had not been care planned. She also acknowledged that R39, R42, R8, and R19's additional diagnoses and current medications had not been utilized in developing the residents' care plans. She stated the residents should have been care planned for areas related to clinical diagnoses, medications, and behavioral concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Interim Director of Nursing (DON) on 10/28/2024 at 7:47 am, she explained that all triggered CAAs identified during the MDS assessment should be included in a resident's current individualized care plan developed by the MDS Coordinator. She added that care plans should consist of clinical diagnoses and other areas of concern related to each resident's medical, emotional, behavioral, and psychosocial status. The DON acknowledged that R39, R42, R8, and R19 should have been care planned for the areas that were not in their care plans. During an interview with the Administrator on 10/28/2024 at 7:56 am, she stated her expectation was that the MDS Coordinator complete a thorough assessment for each resident, inclusive of the MDS CAAs, medical record, clinical diagnoses, medications, behavioral symptoms, psychosocial/mental status, and any other areas identified during the IDT meetings. The Administrator added that she expected the MDS Coordinator to include goals and interventions for each area identified in the resident's individualized comprehensive care plan. The Administrator acknowledged that the care plans for R39, R42, R8, and R19 did not reflect a comprehensive care plan. 37739 5. A review of R3's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Section E (Behavior) documented that rejection of care behaviors was not exhibited, and Section GG (Functional Abilities and Goals) documented R3 required partial/moderate assistance with personal hygiene. A review of the care plan, last updated 10/24/2024, revealed that R3 required set-up assistance from staff with personal hygiene. Observations of R3 on 10/26/2024 at 1:19 pm, 10/27/2024 at 8:36 am, 10/27/2024 at 12:00 pm, and 10/27/2024 at 4:51 pm revealed his face was not shaved. 6. A review of R10's Quarterly MDS assessment dated [DATE] revealed Section E (Behavior) documented that rejection of care behaviors was not exhibited, and Section GG (Functional Abilities and Goals) documented R10 required partial/moderate assistance with personal hygiene. A review of the care plan, last updated 7/17/2024, revealed that R10 required set-up, supervision, and limited assistance with ADL care related to a diagnosis of CVA (cerebrovascular accident) with left-side weakness. The Goal included assistance with ADLs will be provided. The Interventions included keeping the resident's nails clean and cut. Observations on 10/26/2024 at 9:44 am and 10/27/2024 at 12:00 pm revealed R10 had a full beard, and his nails were long and sharp and needed to be trimmed. An observation on 10/27/2024 at 2:09 pm revealed R10's face had been shaven, and he had a goatee, but his nails were still long and not trimmed. 7. A review of the Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS score of 10 (indicating moderate cognitive impairment), and Section J (Health Conditions) documented R13 frequently experienced moderate pain. There was nothing checked in Section L (Oral/Dental Status). A review of the Annual MDS assessment dated [DATE] revealed Section L (Oral/Dental Status) documented obvious or likely cavity or broken natural teeth. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R13's care plan dated 10/18/2024 revealed that R13 had potential for oral/ dental health problems related to having broken teeth and dental caries. A Goal was that R13 would not develop any open area of the gums and would maintain adequate oral hygiene through the next review. Interventions included having dental consultants as needed, observing R13 for oral pain and ulceration, and observing/documenting/reporting to physicians any signs or symptoms of oral/dental problems needing attention. An observation of R13 on 10/26/2024 at 11:20 am revealed missing/broken/decayed teeth. In an interview, R13 stated that the dentist came three or four months ago and was going to do something for him, but they never came back. He stated he does have pain in his mouth and that he had told staff about his pain. During an interview on 10/28/2024 at 1:00 pm, the Administrator confirmed that R13 had not received dental care from a dental provider since 2/21/2024 8. A review of R22's Quarterly MDS assessment dated [DATE] revealed Section E (Behavior) documented that rejection of care behaviors was not exhibited, Section GG (Functional Abilities and Goals) documented R10 required supervision with personal hygiene, and Section L (Oral/Dental Status) documented R22 had obvious or living cavities or broken natural teeth. A review of the care plan, dated 10/24/2024, revealed R22 required supervision with ADL care related to impaired cognition from diagnoses of schizophrenia and bipolar disorder. Interventions included to keep resident's nails clean and cut. Further review of the care plan revealed that R22 had a potential for oral/dental health problems related to missing some natural teeth and had cavities. The Goal was the resident would not develop any open area of the gums and would maintain adequate oral hygiene. The Interventions included coordinating arrangements for dental care as needed/ordered and dental consults as needed. A review of R22's EMR revealed that there was no dental assessment in the clinical record. An observation of R22 on 10/26/2024 at 1:19 pm revealed he had decayed/broken missing teeth. Observations on 10/26/2024 at 1:19 pm and 10/27/2024 at 2:15 pm revealed R22's face was unshaven, and his nails were long and jagged with a dark substance under them. Cross-Reference F677 and F791

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37739 Based on observations, resident and staff interviews, record review, and review of the facility policy titled Activities of Daily Living (ADLs), the facility failed to provide ADL care to three of 38 sampled residents (R) (R3, R10, and R22) related to facial shaving and nail trimming/cleaning. This failure had the potential to cause R3, R10, and R22 to have unmet needs and to feel self-conscious of their appearance. Findings included: A review of the facility policy titled Activities of Daily Living (ADLs), dated 2/12/2022, revealed the Policy was, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. The Policy Explanation and Compliance Guidelines section included . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. A review of R3's electronic medical record (EMR) revealed diagnoses of, but not limited to, dementia with behavioral disturbance, restlessness and agitation, delusional disorders, and hallucinations. A review of R3's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of three (indicating severe cognitive impairment), Section E (Behavior) documented that rejection of care behaviors was not exhibited, and Section GG (Functional Abilities and Goals) documented R3 required partial/moderate assistance with personal hygiene. Observations of R3 on 10/26/2024 at 1:19 pm, 10/27/2024 at 8:36 am, 10/27/2024 at 12:00 pm, and 10/27/2024 at 4:51 pm revealed his face was not shaved. During an interview on 10/28/2024 at 9:47 am, Certified Nursing Assistant (CNA) GG stated that she assisted R3 with a shower on 10/26/2024. She stated that she did not ask the resident if he wanted to be shaved because the men usually refused. She stated that they do not do shower sheets or document anywhere if the residents had their faces shaved. 2. A review of R10's EMR revealed diagnoses of, but not limited to, cerebral infarction (CVA), muscle weakness (generalized), unsteadiness on feet, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. A review of R10's Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS score of 12 (indicating moderate cognitive impairment), Section E (Behavior) documented that rejection of care behaviors was not exhibited, and Section GG (Functional Abilities and Goals) documented R10 required partial/moderate assistance with personal hygiene. (continued on next page)

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	115633	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tybee Island Care Center LLC	26 Van Horne Street Tybee Island, GA 31328

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/26/2024 at 9:44 am revealed R10 had a full beard, and his nails were long and sharp and needed to be trimmed. When asked about cutting his nails, R10 stated, No one does that. He stated no one had asked him if he wanted his nails cut. An observation on 10/27/2024 at 12:00 pm revealed R10's face was not shaved, and his nails had not been trimmed. An observation on 10/27/2024 at 2:09 pm revealed R10's face had been shaven, and he had a goatee, but his nails were still long and not trimmed. During an interview on 10/27/2024 at 12:07 pm, CNA JJ stated that she does assist the residents with shaving and nail care on their shower days. 3. A review of R22's EMR revealed diagnoses included, but not limited to, schizophrenia, bipolar disorder, and muscle weakness. A review of R22's Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS score of 10 (indicating moderate cognitive impairment), Section E (Behavior) documented that rejection of care behaviors was not exhibited, and Section GG (Functional Abilities and Goals) documented R10 required supervision with personal hygiene. An observation on 10/26/2024 at 1:19 pm revealed R22's face was unshaven and his nails were long and jagged with a dark substance under them. An observation on 10/27/2024 at 2:15 pm revealed R22's face was unshaven and his nails were long and with a dark substance under them. In an interview with R22, he stated, All I need is a good shave. During an interview on 10/27/2024 at 2:15 pm, the Wound Care Nurse stated that she helped with shaving, haircuts, and trimming nails, but the residents refused care at times. She confirmed there was no documentation of ADL care being offered or refusals of ADL care. During an interview on 10/27/2024 at 12:02 pm, CNA JJ stated that she showered R22 recently but didn't clip or clean his nails and did not shave him. She stated she did not have a reason why those tasks were not completed.

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F 0689 Level of Harm - Minimal harm or potential for 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** 36200 Based on observations, staff interviews, record review, facility document review, and review of the facility policies titled Fall Risk Assessment and Elopements and Wandering Residents, the facility failed to ensure a complete post-fall assessment was performed for one of 13 residents (R) (R23) who sustained a fall. The facility also failed to complete an elopement assessment for one of 38 sampled R (R6). This deficient practice created a potential risk to the safety and well-being of R23 and R6. Findings include: 1. Review of the facility policy titled Fall Risk Assessment, dated 2023, revealed the Policy was It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Review of the blank facility-provided document titled Fall/Incident Documentation & Reporting indicated When a resident has a fall/incident do the following: 1. Complete the fall/incident packet. 2. Then go to the electronic medical record (EMR). 3. Trigger UDA (User Defined Assessment). Record review revealed R23's diagnoses included, but not limited to, generalized muscle weakness, difficulty walking, insomnia, and unspecified dementia. Review of R23's EMR Progress Notes revealed a fall documented on 10/11/2024. The note documented that R23 was transferred to the hospital after the fall and returned with a cast to the left lower arm due to a fractured wrist. Observation on 10/26/2024 at 9:00 am revealed R23 with a cast on her left arm. During an interview and review of the EMR on 10/27/2024 at 2:25 pm, the Interim Director of Nursing (DON) confirmed a post-fall assessment dated [DATE] was triggered but not fully completed and further confirmed the UDA section was not completed. The Interim DON reported that she was unsure why this portion of the assessment was not completed. In an interview on 10/27/2024 at 4:28 pm, Licensed Practical Nurse (LPN) VV reported if a resident had an unwitnessed fall, the resident should be assessed for injury and neurological status. She further reported that an incident report should be completed after every fall. LPN VV was unsure if the triggered UDA should be completed after every fall event. In an interview on 10/27/2024 at 4:54 pm, the Administrator reported after a fall, an incident report and assessment of the resident should be completed, and all components of the incident report/assessment should be completed including the UDA. She stated she was unsure why the UDA was not triggered and completed for R23's fall on 10/11/2024. 44960 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the facility's undated policy titled Elopements and Wandering Residents revealed the Policy Statement was This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. A review of R6's clinical record revealed diagnoses including, but not limited to, dementia with behaviors, paranoia with schizophrenia, cognitive communication deficit, intellectual disability, and extrapyramidal movement disorders. A review of R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 8 (indicating moderate cognitive impairment), Section E (Behaviors) documented no behaviors exhibited, Section GG (Functional Abilities and Goals) documented R6 was independent with mobility, and Section P (Restraints) documented a wander/elopement alarm was not used. A review of the clinical record revealed no assessment for elopement was completed before R6 eloped from the facility on 9/11/2024. During an interview on 10/26/24 at 11:32 am, R6 stated he recalled leaving the facility a few weeks ago. R6 stated he left the facility because he was tired of living there. During an interview on 10/27/2024 at 10:05 am, the Administrator revealed she recalled getting a telephone call that R6 was found outside the facility ambulating about a block from the facility. She further stated she directed Staff Member MM to escort the resident back to the facility. She stated R6 was escorted back to the facility, was assessed, and responsible parties were notified.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37739 Based on observations, resident and staff interviews, record review, and review of the facility policy titled Dental Services, the facility failed to provide routine and emergency dental services for three of 38 sampled residents (R) (R3, R13, and R22). This failure placed R3, R13, and R22 at risk for unmet needs and a diminished quality of life. Findings included: A review of the facility's undated policy titled Dental Services revealed the Policy was, It is the intent of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. The Policy Explanation and Compliance Guidelines section included . 9. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. 1. A review of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE]. A review of the EMR revealed R3's funding source was documented as Medicaid Georgia (GA). A review of R3's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Section L (Oral/Dental Status) documented R3 had no natural teeth or tooth fragments and was edentulous. A review of R3's EMR revealed that there was no dental assessment in the clinical record. Observations of R3 on 10/26/2024 at 1:19 pm, 10/27/2024 at 8:36 am, 10/27/2024 at 12:00 pm, and 10/27/2024 at 4:51 pm revealed he had no teeth or dentures. 2. A review of the EMR revealed that R13 was admitted to the facility on [DATE]. A review of the EMR revealed R13's funding source was documented as Medicaid GA. A review of the Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS score of 10 (indicating moderate cognitive impairment), and Section J (Health Conditions) documented R13 frequently experienced moderate pain. There was nothing checked in Section L (Oral/Dental Status). A review of the Annual MDS assessment dated [DATE] revealed Section L (Oral/Dental Status) documented obvious or likely cavity or broken natural teeth. A review of the last dental exam documents dated 2/21/2024 revealed that R13 needed full mouth extractions under sedation due to R13 experiencing pain. He was ordered an antibiotic for an infection (clindamycin 150 milligrams (mg) every six hours until gone). The documentation further noted that there was a referral to an oral surgeon due to sedation and that the referral was sent to the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of R13 on 10/26/2024 at 11:20 am revealed missing/broken/decayed teeth. In an interview, R13 stated that the dentist came three or four months ago and was going to do something for him, but they never came back. He stated he does have pain in his mouth and that he had told staff about his pain. 3. A review of the EMR revealed that R22 was admitted to the facility on [DATE]. A review of the EMR revealed R22's funding source was documented as Medicaid GA. A review of the Quarterly MDS assessment dated [DATE] revealed Section L (Oral/Dental Status) documented R22 had obvious or living cavities or broken natural teeth. A review of R22's EMR revealed that there was no dental assessment in the clinical record. An observation of R22 on 10/26/2024 at 1:19 pm revealed he had decayed/broken missing teeth. During an interview on 10/27/2024 at 12:12 pm, the Interim Director of Nursing (DON) stated that the Dental Provider last provided services in July 2024. She stated dental services were scheduled quarterly, by referral from staff, and on admission if they needed an assessment. She further stated R13 had stated that he had pain, but the location of the pain was not documented. She stated that the nurse should have documented the location of the pain. During an interview on 10/27/2024 at 12:26 pm, the Administrator confirmed that R13 went to the dental clinic twice due to pain and dental concerns. She stated, We have been working on his teeth for a while. Yes, he has mouth pain. She further stated the facility had changed dental providers in July 2024 and that she and the DON had been working to get residents on the list for the dental provider since then. During an interview on 10/28/2024 at 1:00 pm, the Administrator confirmed that R3 and R22 did not have any initial or routine dental assessment from a dental provider since admission to the facility. During an interview on 10/28/2024 at 1:00 pm, the Administrator confirmed that R13 had not received dental care from a dental provider since 2/21/2024 and that there was a referral to an oral surgeon due to sedation needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36200 Based on observations and staff interviews, the facility failed to label and date items in the freezer, failed to ensure items in dry food storage were not expired, failed to prevent cross-contamination hazards by storing scoops in the container, failed to wear hairnets, and failed to ensure routine cleaning and sanitation of the kitchen. This deficient practice had the potential to place 49 of 49 residents who received an oral diet from the kitchen at risk of foodborne illness. Findings Include: During the initial kitchen tour on [DATE] at 7:47 am the following items were identified: 1. Dietary Aide AA and Dietary Aide BB were not wearing hairnets upon the surveyor's entry into the kitchen. 2. Items in the white standup freezer were not labeled or dated, including pancakes, cookies, biscuits, sausage, and fish nuggets. 3. In the dry storage pantry there were: a. Three bottles of expired thickened water with a use-by date of [DATE]. b. There were four plastic storage containers with sugar, rice, and flour with scoops on top and not in a bag. One scoop was in the container. During an interview on [DATE] at 7:59 am with [NAME] FF, she confirmed the items in the standup freezer were not labeled or dated and reported that items in the freezer should have had a label on them. During an interview on [DATE] at 8:07 am with Dietary Aide AA, he confirmed that scoops should be kept on top of the container and bagged. During an interview with the Dietary Manager (DM) on [DATE] at 10:51 am, the DM acknowledged that storage bins did not have use by date, and she also confirmed that the scoops should not be kept in the containers with the rice, sugar, and flour. It was reported that the kitchen is deep cleaned monthly, and it was last deep clean was three weeks ago. The DM was unable to provide documentation of the cleaning. During a secondary tour of the kitchen on [DATE] at 11:00 am, observation revealed there were four bags of unlabeled and dated meat in the walk-in freezer that were identified as beef stew by the DM. Observation on [DATE] at 11:06 am revealed [NAME] CC who was observed to lick her gloved finger when sampling pureed sweet peas. [NAME] CC was not observed washing hands or changing gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and observation on [DATE] at 12:00 pm, the DM reported an area on the floor with build-up was there because they were unable to move the table from the area to clean that area of the floor. The refrigerator was noted to have rusted, and the DM reported that it was due to the cleaning product that was used on the refrigerator. She reported that she has been out for a while, and the cleaning schedule may have gotten off track during her absence. An email from the Licensed Dietitian (LD) stated, The Nutritional Services Sanitation Inspection was completed by the LD on [DATE] and identified concerns with items not being labeled and dated. In an interview on [DATE] at 4:54 pm, the Administrator acknowledged that the items in the refrigerator and freezer should be labeled and dated. The Administrator stated she was not sure of the cleaning schedule but acknowledged that the kitchen should be cleaned daily. The Administrator further reported that hairnets should be worn by staff when in the kitchen. Lastly, the Administrator confirmed that [NAME] CC should not have sampled the sweet peas from her finger.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 36200 Based on observations and staff interviews, the facility failed to ensure the outdoor garbage and refuse area was maintained in a sanitary manner. This deficient practice had the potential to attract pests and rodents and transfer harmful microorganisms to food leading to food borne illness for the 49 residents residing in the facility. Findings include: During the initial observation of the dumpster area on 10/26/2024 at 8:30 am with Dietary Aide AA, there were two blue dumpsters observed with the door fully opened on one and partially opened on the other with a brief hanging out of the opening. During a second tour of the dumpster area on 10/27/2024 at 10:36 am with the Dietary Manager (DM), trash was on the ground to the right of one of the dumpsters and the door was opened on the other dumpster. The DM acknowledged the trash on the ground and that the dumpster doors should always be closed. During an interview with the Administrator on 10/27/2024 at 4:54 pm, it was acknowledged that the dumpsters should be kept closed on both the top and the sides. The Administrator went on to report that two dumpsters had been placed for nursing to put their items that would be separate from where dietary puts their trash.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 36200 Based on observations, staff interviews, record review, and review of the facility policies titled, Hand Hygiene and Infection Surveillance, the facility failed to maintain an effective infection prevention control program to ensure proper sanitation between resident interactions, failed to ensure beverages were covered before delivering on the hallway, failed to ensure hand sanitation when delivery meal trays, and failed to demonstrate ongoing surveillance, recognition, investigation, and control of infection to prevent the onset and spread of infection. These deficient practices placed all 49 residents residing in the facility at risk of contracting avoidable infections. Findings include: 1. Review of the facility policy titled Hand Hygiene, dated 2023, indicated the following: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Observation on 10/26/2024 at 12:36 pm, in the dining room, revealed Registered Nurse (RN) UU with gloves on going from table to table cleaning multiple resident's hands with wipes. RN UU did not change gloves between residents. Observation on 10/26/2024 at 12:51 pm of a lunch food tray cart leaving the dining room and pushed to a resident hallway revealed there were seven trays on the cart, each with an uncovered beverage cup, during the meal delivery. Observation on 10/27/2024 at 1:09 pm of lunch meal tray delivery on a resident hallway by Certified Nursing Aide (CNA) TT revealed CNA TT delivering 12 meal trays to resident rooms. She was observed moving items on bedside tables and sometimes touching the residents in the rooms when delivering the trays. CNA TT did not use hand sanitizer or wash her hands between each delivery. During an interview with CNA TT on 10/27/2024 at 3:02 pm, it was reported that hand sanitizer was not used due to eczema. She reported typically she would use gloves but was informed that gloves could not be worn in the hallways with the surveyors in the building. CNA TT reported that the beverage cups were never covered when being delivered down the hallway, and she had not been directed to cover the cups. During an interview with the Administrator on 10/28/2024 at 2:43 pm, she stated staff should cover all drinks with a lid before distributing them down the hallways. She added that she did not know why the staff had not been covering the drinks, and she said it was the nursing staff's responsibility to ensure drinks were covered during transport. During further interview, she stated she expected staff to wash their hands and/or use hand sanitizer between resident contact and before and after entering and exiting a resident's room. She stated if the staff member had a skin condition that contraindicated the use of a hand sanitizer, she would expect the staff member to wash their hands when entering and exiting a resident's room and when assisting a resident. The Administrator indicated she had no problem or issues with the staff utilizing gloves to provide care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Interim Director of Nursing (DON) on 10/28/2024 at 2:51 pm, she stated that she expected staff to cover all drinks with lids before transporting them outside the dining room. The Interim DON stated it was the nursing staff's responsibility to ensure the drinks were covered. 44960 2. Review of the facility's policy titled Infection Surveillance, revised 7/1/2024, revealed the Policy Statement was A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention practices in order to reduce infections and prevent the spread of infections. Review of the Infection Control Tracking Reports revealed the facility did not have documented evidence of infection control surveillance data for nine of ten months (January through September) for 2024. During an interview with the Interim Director of Nursing (DON)/ Infection Control Preventionist (ICP) on 10/27/2024 at 10:41 am, she stated she had taken the role of the facility's ICP in August of 2024 and was unable to locate any documentation for the monthly infection controls tracking system for 2024. Further interview revealed she did not know where the infection control tracking data for the past nine months (January through September) was and was only able to find infection control tracking data for 2021 and 2022. During an interview on 10/27/2024 at 2:40 pm, the Administrator stated she thought there was a more updated book with the 2024 monthly infection control surveillance data but could not locate it.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37739 Based on observations and staff interviews, the facility failed to ensure that the Nursing Call System was functioning and operational for four of 26 resident rooms/bathrooms (Rooms 16, 17, 18, and 7). This failure placed the residents residing in the rooms at risk of accident, injury, or unmet needs related to an inability to call for staff assistance. Findings included: During an observation on 10/26/2024 at 9:44 am, the call light cord in room [ROOM NUMBER] was observed on the floor and not plugged into the Nursing Call Light Panel on the wall behind the resident bed. Certified Nursing Assistant (CNA) GG entered the room and verified the cord was on the floor and unplugged from the wall. When she tried to plug it back up, it was observed that the Nursing Call Light Panel only had one hole to accommodate one cord. There were two residents assigned to room [ROOM NUMBER]. CNA GG stated she would notify the nurse and the maintenance department. During an observation on 10/26/2024 at 9:48 am of the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER], observation revealed no Nursing Call Light Panel was accessible in the bathroom. There was a gray panel with no accommodation for a call light cord. CNA GG confirmed this observation. During an observation on 10/26/2024 at 10:36 am in room [ROOM NUMBER], the call light cord was not functioning for the resident in Bed B. During observations and interview on 10/26/2024 at 10:53 am, the Interim Director of Nursing (DON) confirmed the Nursing Call Light Panel in room [ROOM NUMBER] only had one hole to accommodate one resident call light, even though two residents were assigned to that room. She further confirmed the resident's call light cord was not functioning to activate the Nursing Call System for the resident in room [ROOM NUMBER] Bed B. During an observation on 10/26/2024 at 10:57 am in room [ROOM NUMBER], the call light was pressed multiple times but wouldn't come on when the resident pressed the button to alert staff that they needed assistance. Registered Nurse (RN) KK was called into the room and confirmed that the Nursing Call System was not functioning. She stated that a new call light cord may be needed. During a second observation on 10/28/2024 at 11:47 am in room [ROOM NUMBER], the Nursing Call System had not been repaired and was not functional to accommodate both residents in the room. At this time, the Administrator and Regional Director of Environmental Services (RDES) stated staff had not informed the Administrator that the call lights were not functional in Rooms 16, 17,18, and 7 and in the shared bathroom of rooms [ROOM NUMBERS]. The RDES stated that he visited the facility twice a month and did rounds but was not aware of the Nursing Call System not functioning for all residents.