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	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tybee Island Trails of Journey 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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, staff interviews, record review, and a review of facility's policy titled Pain Management and Wound Treatment Management, the facility failed to stop and address a resident pulling back during a dressing change and facial grimacing expressions of pain during wound care for one resident (R) (R33) of two residents observed for wound care. Actual harm occurred on 1/28/2026 when Licensed Practical Nurse (LPN) AA failed to assess and administer pain medication to R33 prior to providing wound care treatment, which resulted in pain during the treatment.Findings Include: Review of the facility policy titled Pain Management, date reviewed/revised 04/1/2025, revealed the Policy section included, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The Policy Explanation and Compliance Guidelines section included, Recognition: . the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. 2. Faculty staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: . facial expression (e.g., [such as] grimacing, frowning, .).Review of the facility's undated policy titled Wound Treatment Management revealed the Policy Explanation and Compliance Guidelines section included, .5. Treatment decisions will be based on . b. Characteristics of the wound: .iv. the presence of pain.Review of the quarterly Minimum Data Set (MDS) assessment for R33, dated 11/27/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 00 (indicating was unable to complete). Section GG (Functional Abilities and Goals) revealed the resident was dependent for all care. Section I (Active Diagnosis) revealed diagnosis of, but not all-inclusive, encephalopathy, dementia, schizophrenia, and cognitive communication deficit.A review of the care plan for R33 revealed the resident had severely impaired cognition related to dementia and schizophrenia, and staff would anticipate the resident's needs and provide care. Further review revealed the resident was unable to effectively communicate the presence of pain and was dependent on staff to monitor and identify signs and symptoms of pain and to provide the appropriate interventions. Interventions included monitoring for signs of non-verbal pain, including facial grimacing, and administering pain medication per the physician's orders.Review of the physician's orders for R33 revealed an order dated 8/16/2021 for Mapap (a pain reliever), give 2 tablets orally every 6 hours as needed for pain.Review of the Medication Administration Record (MAR) for R33, dated 01/01/2026 - 01/31/2026, revealed the pain medication was administered one time, on 1/28/2026 at 12:04 PM.During wound care observation on 01/28/2026 at 10:56 AM with Licensed Practical Nurse (LPN) AA, R33 was observed to exhibit facial grimacing and pulling away from the dressing change.In an interview on 01/28/2026 at 11:09 AM, LPN AA confirmed that the resident exhibited non-verbal signs of pain during the wound care. She stated that the resident was not medicated for pain before the procedure, and she did not assess the pain prior to the change of dressing. She confirmed the resident was grimacing and pulling back, and she continued to change the dressing. She stated that once the resident experienced pain, she should not have continued with the dressing change and should have notified the nurse.In an interview on 01/29/2026 at 05:14 PM, the Unit Manager stated the wound care nurse should assess pain prior to providing wound care and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0697 Level of Harm - Actual harm Residents Affected - Few	return to perform the wound care after treatment of pain.In an interview on 01/30/2026 at 06:45 AM, the Director of Nursing (DON) stated the wound care nurse should address pain prior to a dressing change. She stated that the nurse should ask the resident about pain and, if needed, have the nurse treat pain and move to another resident while the medication kicks in. She further stated that if a resident complained of pain during treatment, continue to provide care, being as gentle as possible, and treat pain once care is complete.

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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 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. Based on observations, staff interviews, and review of the facility's policy titled Food Safety Requirements, the facility failed to label, store, prepare, and discard food under sanitary conditions. In addition, the facility failed to ensure the cleanliness of the kitchen floors and equipment used for residents. The deficient practices had the potential to place the 48 residents receiving nutrition and hydration at risk for foodborne illness.Findings include: Review of the facility's policy titled Food Safety Requirements, revised on 03/25/2025, documented under Policy Explanation and Compliance Guidelines number 1-e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food; number 3- iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (when applicable)/ discarded; number 8-e. Cleaning and sanitizing the internal components of the ice machine according to the manufacturer's guidelines. Observation tour of the kitchen on 01/27/2026, beginning at 11:55 AM, with the Certified Dietary Manager (CDM), revealed the following concerns were identified and confirmed:Refrigerator one contained a bottle of red sauce labeled 12/31/2025.Refrigerator one contained a block of butter partially covered without a label or date.Refrigerator two contained a bottle of barbecue sauce without an expiration date.The dry pantry contained a bag of lettuce with wilted, brown leaves.A metal shelf on the side of the stand-up freezer contained a black plastic container that contained heads of cabbage that were wilted with patches of yellow leaves and black spots, without a label or date.The walk-in freezer contained one partially covered pie without an open or expiration date.The stand-up freezer contained five unidentified bags of meat without labels.The dry pantry contained one box of bananas on the floor, next to a plastic container of sanitizing wash and walk solution.A refrigerator contained three jars of apple sauce without an expiration date.The can opener had a greasy, black substance.Prep table had paper, dishcloth, and cup lids. The kitchen floor under the can opener had a sticky red substance covering that area.The vents and light fixtures over the stove had thick, grey particles on them. The hand sanitizer dispenser next to the hand-washing sink was covered with thick, grey particles.A rolling serving cart with boxes, empty cans, lettuce with brown leaves, and empty thickener containers to be disposed of. During the tour, the CDM confirmed all identified concerns and stated the staff needed a lot of education on labeling, dating, and discarding items. She stated that the kitchen was due for a deep cleaning and did not know when it had last been cleaned. She confirmed that vents, light fixtures, and a hand sanitizer dispenser next to the hand-washing sink were covered with thick, grey particles. CDM confirmed that empty boxes, empty cans, lettuce with brown leaves, and empty thickener containers were placed on top of the rolling serving cart. She confirmed that all items should be discarded in the trash bin. She confirmed that the ice machine had a dried mixture of white and rust residue on the front, along the inner lip of the bin opening, and on the inside of the lid.Observation and interview on 01/28/2026 at 1:15 PM with the CDM confirmed that the ice machine located in the dining hall and used for the residents contained a dried mixture of a white and rust colored residue on the front of the machine, along the inner lip of the bin opening, and on the inside of the lid. She confirmed that black specks were present around the dispenser inside the ice machine and that the ice scoop was in the ice bin, uncovered. She confirmed it needed cleaning and that it was the responsibility of the maintenance department. She also confirmed that an uncovered trash can should not be placed in front of the ice machine and that all trash cans must be kept covered. An interview with the Maintenance Director on 01/28/2026 at 2:18 PM revealed that the exterior and interior of the ice machine had dried water stains and rust-colored residue. He confirmed that black specks were present inside the ice and that the ice scoop was in the ice bin, uncovered. The Maintenance Director confirmed that housekeeping and maintenance are responsible for keeping the ice machines clean. The maintenance Director also confirmed that the air conditioning vents in the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dining area ceiling were covered with thick, grey particles. He confirmed he was unsure when the ice machine or the vents were last cleaned. He confirmed that housekeeping and maintenance were responsible for keeping them both clean.

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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. Based on observation, staff and resident interviews, and record review, the facility failed to ensure three of 32 sampled residents' (R) (R2, R1, and R45) were treated with dignity. This deficient practice had the potential to place R2, R1, and R45 at risk of a diminished quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life.Findings include: 1. Review of the significant change Minimum Data Set (MDS) for R2, dated 12/15/2025, revealed that Section C (Cognitive Patterns) documented that R2 had a Brief Interview for Mental Status (BIMS) score of 14 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that R2 was moderate assistance with eating and maximal assistance with oral hygiene. Section I (Active Diagnoses) documented diagnoses of, but not all inclusive, encephalopathy, unsteadiness on feet, dysphagia, gastrostomy, end-stage renal disease, hypothyroidism, type two diabetes mellitus, and acute respiratory failure with hypoxia. Review of the care plan for R2, dated 12/19/2025, revealed that R2 had an activity of daily living (ADL) self-care performance deficit, and her ADL requirements may vary from day to day. She required supervision to substantial assistance with ADLs. She uses a wheelchair for mobility. Intervention includes providing assistance with ADLs as needed. Record review revealed that R2 had an order 12/8/2025 for a pureed texture, nectar consistency pleasure tray. Observation 01/27/2026 at 1:20 PM revealed Certified Nursing Assistant (CNA) FF feeding R2 while standing over her. In an interview on 1/27/2026 at 1:27 PM, CNA FF confirmed that she was standing while feeding R2. She stated that she should not stand to feed residents. 2. Review of the quarterly MDS for R1, dated 12/10/2025, revealed that Section C (Cognitive Patterns) documented that R1 had a Brief Interview for Mental Status (BIMS) score of 0 (indicating severe cognitive impairment). Section I (Active Diagnosis) documented diagnosis of, but not all inclusive, Down syndrome, bipolar disorder, cognitive communication deficit, obstructive and reflux uropathy, and muscle weakness. Review of the care plan for R1, dated 01/12/2026, revealed that R1 had a urinary catheter and is at risk for urinary tract infections and injury. The urinary catheter was related to obstructive uropathy and benign prostate hypertrophy. Interventions include providing urinary catheter care per facility practice. Observation on 01/30/2026 at 6:02 AM revealed that Licensed Practical Nurse (LPN) BB knocked on the resident's door, introduced herself, and explained the procedure to R1. Observed revealed R1 in bed A. Further observation revealed that LPN BB did not pull the privacy curtain during catheter care for R1. Observation revealed that R1's roommate was in bed B during the care provided to R1. In an interview, LPN BB confirmed that she did not pull the privacy curtain while providing care and that she should have. In an interview on 01/30/2026 at 9:09 AM, the Unit Manager stated that the staff should close the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door and pull the privacy curtain while providing care if another resident was in the room. In an interview on 01/30/2026 at 8:46 AM, the Administrator stated that staff should provide privacy in the room by pulling the curtain and closing the door, and if the resident was by the window, the blind should be closed. 3. Review of the quarterly MDS assessment for R45, dated 12/18/2025, revealed that Section C (Cognitive Patterns) documented that R45 had a BIMS score of 2 (indicating cognitive impairment). GG Section GG (Functional Abilities and Goals) documented that R45 needed supervision and touching assistance with eating. Review of the clinical record for R45 revealed diagnoses of, but not all inclusive, dementia, unspecified severity, with other behavioral disturbance, and dysphagia, oropharyngeal phase. Review of the physician orders for R45 revealed an order dated 12/8/2025 for a regular diet, mechanical soft texture, and thin consistency. Observation 01/27/2026 at 1:28 PM revealed Registered Nurse (RN) Unit Manager II standing while feeding R45 her meal. In an interview on 01/27/2026 at 1:45 PM, RN Unit Manager II confirmed that she was standing while feeding the resident her lunch and stated that she should not stand to feed residents. In an interview on 01/30/2026 at 6:45 AM, the Director of Nursing (DON) stated that staff should sit while feeding the residents. In an interview on 01/30/2026 at 8:46 AM, the Administrator stated that staff should sit while feeding residents.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and staff interview, the facility failed to notify the resident and/or the resident's responsible party when their personal funds were within $200.00 of the Social Security Income (SSI) limit and when accounts exceeded the $200.00 limit for one of 48 resident (R) (R43) accounts reviewed.Findings include:Review of the electronic health records (EHR) for R43 revealed diagnoses including, but not limited to, paranoid schizophrenia, schizophrenia, and brief psychotic disorder. Review of the quarterly Minimum Data Set (MDS) assessment for R43, dated 12/9/2025, revealed a Brief Interview Mental Status Score (BIMS) score of 11, indicating moderate cognitive impairment.Review of the Trial Balance report dated 01/30/2066 revealed the trust fund account for R43 exceeded the SSI limit of $2000.00.Review of the account document titled Resident Statement Landscape revealed that R43 was awarded $13,115.98 (March 2025), and the remaining balance in her account was $4,856.73.There was no documented evidence that the resident, or the responsible party, was notified of the amounts exceeding the SSI limit.During an interview on 01/30/2026 at 4:10 PM, R43 reported being unaware of the exact amount in her account. She stated she was informed on 01/30/2026 by the office manager staff of having $6,000.00 in her account.During an interview on 01/30/2026 at 2:00 PM, the Business Office Manager (BOM)/Financial Coordinator stated the SSI limit for the State of Georgia was $2000.00. The BOM/Financial Coordinator confirmed the resident's account balance and confirmed the facility had not notified the resident and/or the resident's responsible party of the excess in her account. The BOM/Financial Coordinator reported that she was instructed to keep resident fund accounts under $2,000.00 to qualify for Medicaid. She confirmed that the patient's liability for R48's accounts had already been pulled out for the month of January 2026 and that the remaining balance left in the resident's account was $4,856.73.A policy was requested, but was not provided.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to ensure submission to the state-designated authority for a Preadmission Screening and Resident Review (PASRR) Level II for two residents (R) (R1 and R19) reviewed for PASRR from a sample of 32 residents. This deficient practice increased the potential to place R1 and R19 at risk of not receiving services and/or care according to their needs.Findings include: 1. Review of the electronic health record (EHR) under the Diagnosis tab for R1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, bipolar disorder and Down syndrome. Review of the quarterly Minimum Data Set (MDS) assessment for R1, dated 12/10/2025, revealed that Section C (Cognitive Patterns) documented that R1 had a Brief Interview for Mental Status (BIMS) score of 0 (indicating severe cognitive impairment). Section I (Active Diagnosis) documented diagnosis of, but not all inclusive, Down syndrome and bipolar disorder. Review of the hospital record for R1 revealed documentation dated 09/02/2025 that R1's active problem list included, but was not all-inclusive, for bipolar affective disorder and intellectual developmental disorder, mild. Past medical history included Down syndrome. A review of R1's orders revealed there was no psychiatric order for R1. Review of the PASRR Level I Assessment and DMA 6 for R1, dated 11/15/2025, revealed that diagnoses of schizophrenia and bipolar disorder were not marked. Review of the clinical record for R1 revealed no submissions for a PASRR Level II after admission.Review of the facility-provided list of residents with Level II PASRR revealed that R1's name was not listed. In an interview on 01/30/2026 at 11:00 AM, the Business Development Specialist confirmed that R1 did not have a PASRR Level II. She stated she would initiate PASRR Level II and that she should have initiated one on R1's admission. In an interview on 01/30/2026 at 8:46 AM, the Interim Administrator revealed that PSARR Level II was completed by the admission Coordinator and should be initiated on admission, and if during admission, a PASRR Level II was not initiated, it should be completed at the onset of admission. 2. Review of the EHR, under the Diagnosis tab, revealed that R19 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, other schizophrenia and bipolar disorder, unspecified. Review of R19 's quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment; Section I (Active Diagnosis) documented schizophrenia and bipolar disorder. Section N (Medications) documented that the resident received antipsychotic and antidepressant medications during the look-back period of assessment. Review of R19's EHR under the Orders tab revealed physician orders dated 12/2/2025 for olanzapine oral tablet 15 milligrams (mg), give 15 mg by mouth at bedtime, related to other schizophrenia and an (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order dated 09/4/2025 for Depakote oral tablet delayed release 500 mg, give 1 tablet by mouth three times a day, related to other schizophrenia and bipolar disorder, unspecified. Review of the PASRR Level I Assessment for R19, dated 11/7/2024, revealed that the document did not indicate diagnoses of schizophrenia or bipolar disorder. Review of the clinical records for R19 revealed no submissions for a PASRR Level II after admission. Review of the facility-provided list of residents with Level II PASRR revealed that R19's name was not listed. In an interview on 01/29/2026 at 2:30 PM, the Business Development Specialist DD confirmed the resident did not have a PASRR Level II. She confirmed the resident had qualifying diagnoses and stated that since the resident has not had any increase in behaviors, she had not submitted a PASRR Level II. She stated that if the resident exhibited an increase in behaviors, she would submit for a PASRR Level II.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, the facility failed to ensure that one of two medication rooms was free of expired medication. This deficient practice had the potential to place residents at risk of receiving expired medications. Findings include:Observation on 01/29/2026 at 9:08 AM, of the supply room and over-the-counter medication room on Hall One with the Unit Manager, revealed two bottles of calcium 600 milligrams (mg) plus vitamin D3 400 units expired on 12/2025, three bottles of aspirin 325 mg expired 10/2025, one bottle of aspirin 325 mg expired 12/2025, two bottles of calcium 600 plus D3 expired 11/2025, one milk of magnesium expired 10/2025. The Unit Manager confirmed the expired medications. She stated the nurse was responsible for confirming medications were not expired before removing them from the storage closet. In an interview on 1/29/2026 at 9:26 AM, the Central Supply Clerk confirmed that the medications had expired. She stated that she stocks the medication and supply room and places the medications on the shelves according to the medication. She further stated she checked for expired medication every other day and removed them from the shelves. In an interview on 1/30/2026 at 6:45 AM, the Director of Nursing (DON) stated that medication storage was completed by nurses and central supply staff. The DON stated that Central Supply stocks, rotates supplies, and removes expired medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, and a review of the facility's policy titled Enhanced Barrier Precautions, the facility failed to ensure infection control practices were followed for four of 32 sampled residents (R) (R33, R7, R30, and R40). This deficient practice had the potential to place R33, R7, R30, and R40 at risk of infection due to cross-contamination and exposure. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, revised 4/1/2025, revealed the Policy section stated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The Policy Explanation and Compliance Guidelines section included, . 2. Initiation of Enhanced Barrier Precautions: . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds, . indwelling medical devices (e.g. [such as] central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC [Peripherally Inserted Central Catheter] lines, midline catheters) even if the resident was not known to be infected or colonized with a MDRO (multidrug resistant organism). 1. Review of the quarterly Minimum Data Set (MDS) for R33, dated 11/27/2025, revealed that Section GG (Functional Abilities and Goals) documented that the resident was dependent for all care. Review of the care plan for R33, dated 01/7/2026, revealed the resident had a potential for pressure ulcer development related to bowel and bladder incontinence and impaired cognition from diagnoses of dementia and schizophrenia, and an abrasion to the top of the second toe on the right foot. Interventions included examining the resident's skin daily for open or reddened areas and reporting abnormal findings to the nurse, maintaining dignity and privacy, encouraging the resident to change soiled clothing and assist as needed, using a pressure reduction mattress, providing treatment as ordered, and a weekly skin audit by a licensed nurse. Review of the physician orders for R33 revealed an order dated 01/22/2026 to cleanse the right foot anterior with Dakin's solution, pat dry, apply alginate, and apply an island dressing, then apply a boot for protection every day shift. Observation on 01/28/2026 at 10:56 AM revealed that Licensed Practical Nurse (LPN) AA completed wound care to the right lateral anterior foot wound, wearing gloves and a mask. Observation revealed she changed gloves during the procedure, but did not sanitize her hands between glove changes or wear a gown. In an interview on 01/28/2026 at 11:09 AM, LPN AA confirmed that she did not wear a gown during the dressing change and did not sanitize her hands between glove changes. 2. Review of the quarterly MDS for R7, dated 12/15/2025, revealed that Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive anemia, hypertension, renal insufficiency, diabetes mellitus, depression, bipolar disorder, schizophrenia, pressure ulcer of left heel, pressure ulcer of right lower back stage 4, pressure ulcer of left lower back stage 4. Review of the care plan for R7, dated 11/12/2025, revealed that R7 requires enhanced barrier precautions (EBP) due to a pressure ulcer on the right and left ischium. Interventions included wearing gowns and gloves during high-contact resident care activities, ensuring EBP signage is (continued on next page)

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	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tybee Island Trails of Journey LLC	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.

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