STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115730	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood at Tybee Island of Journey Llc, The	7 Rosewood Avenue 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policies titled Abuse Neglect and Exploitation and Proper Use of Bed Rails, the facility failed to protect one Resident (R) (R3) from neglect by not providing adequate supervision and oversight to ensure the resident was free from the risk of entrapment related to the use of side rails. Specifically, the assigned Certified Nursing Assistant (CNA) FF failed to provide required monitoring and assistance with Activities of Daily Living (ADL) care for R3 on [DATE] between 12:46 am to 4:30 am. As a result, R3 was found unresponsive with agonal breathing and entrapped in the siderails for an unknown amount of time. R3 required emergency resuscitation by Emergency Medical Services (EMS) enroute to the hospital and had to be intubated (a procedure to insert a tube into the airway to maintain breathing). R3 later expired at the hospital on [DATE]. The facility's failure to protect the resident from neglect caused or was likely to cause serious injury, harm, impairment, or death to the resident. Immediate Jeopardy was identified on [DATE] at 8:16 am and was determined to have existed on [DATE] at appropriately 5:00 am. The facility's Administrator was notified that an acceptable IJ removal plan was received on [DATE] at 9:38 am. The surveyor validated the full implementation of the facility's removal plan, and the Administrator was notified on [DATE] that the Immediacy had been removed on [DATE].Findings include:Review of the facility's policy titled Abuse Neglect and Exploitation dated [DATE] under Policy section revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect is defined as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will develop and implement written policies and procedures that: prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegations; and include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and establish coordination with the QAPI program.Review of the facility's policy titled Proper Use of Bed Rails dated [DATE] under Policy section revealed, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Entrapment is defined as an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. The facility will assess to determine if the bed rails meets the definition of a restraint. A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. If it is determined to be a restraint, the facility will follow their procedures related to physical restraints.Review of medical records revealed, R3 was admitted to the facility on [DATE] with diagnoses that included but not limited to, acute and subacute (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	infective endocarditis, end stage renal disease, unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, bacteremia, and other cervical disc degeneration, unspecified cervical region.Review of the Medicare 5 (five)-day Minimum Data Set (MDS) for R3 dated [DATE] for Section C (Cognitive Pattern) revealed, a Brief Interview of Mental Status (BIMS) score of eight which indicated moderate cognitive impairment; Section GG (Functional Abilities and Goals) revealed, the resident was dependent on staff for all ADLs and Section P (Restraints and Alarms) revealed, bed rails were not used.Review of R3's admission assessment dated [DATE] for Risks vs. Benefits revealed, side rails was placed to assist with movement within the bed (moving up and down for positioning).Review of the facility's records revealed there was no evidence that the safe rail spacing and regular inspection of side rails/bed had been completed.Record review revealed nursing staff observed the resident at 12:46 am and provided R3 with a sponge bath. There was no other evidence that the resident was monitored and provided with ADL care assistance on [DATE] between 12:46 am to 4:30 am.Review of the Progress Notes for R3 dated [DATE] revealed, Registered Nurse (RN) EE documented, 515a CNA staff reported Res had fallen out of bed and needs assist getting him back to bed. Only the lower body was distended out of bed. Staff x3 was able to safely transfer him back in bed. No verbal interaction noted from Res. No eye contact VS/103/69 97% RA 97.7 92. Notified MD, Admin, DON and family. Called 911 to transfer to ER for eval and treat.Review of the Hospital emergency room (ER) notes dated [DATE] revealed that R3 was brought in by EMS for altered mental status and respiratory failure. Further review of the notes revealed, brought in by EMS per reports, recent extended hospitalization, unknown diagnosis, unknown medication, found at some point altered, decreased responsiveness, found to have agonal respirations with Glasgow Coma Scale (GCS) of three on EMS arrival, bagging. Patient is wearing a Do not Resuscitate (DNR) wrist band but uncertain of his code status. No further available information. No real records sent. Patient was in a dirty Cervical (C)-collar at his facility.Review of the death certificate revealed R3 expired on [DATE]. The cause of death listed was pulseless electrical activity, metabolic acidosis, end stage renal disease, and sepsis due to unspecified organism.During an interview with RN EE on [DATE] at 4:14 pm, she stated that on [DATE], around 5:00 am, CNA FF came to her and told her that she needed help with R3. RN EE stated that when she went into his room, she saw his lower part of his body hanging off the bed, but the top part of his body was still on the bed. RN EE stated that his elbow (she motioned her right elbow) was wedged into the 1/2 side rail. RN EE stated that because his elbow was wedged into the side rail, it took three staff members to position him and get him back in the bed. RN EE stated that R3 was quadriplegic, and she asked CNA FF how he got into that position. RN EE stated that CNA FF stated that she did not know because that was her first time seeing him since she came to work at 11:00 pm. RN EE further stated that R3 was not as alert as when she put him in bed. She stated that he went to bed talking and making sense. RN EE stated she performed sternum rubs on him, but he did not respond, she stated that his eyes were open, but he was not focusing. RN EE stated that she sent him to the hospital because he was not responding. R3 did not return to the facility and expired on [DATE].Interview with CNA FF on [DATE] at 3:15 pm revealed that she reported to both nurses to come help her get R3 off the floor. She stated she came in at 11:00 pm and R3 was still up and his bed was to the floor. CNA FF stated she saw R3 again between 4:30 am to 5:00 am. She stated that she placed the call light in his hands and he would usually press the call light if he wanted something but he did not press his call light all night. CNA FF stated when she went in his room between 4:40 am to 5:00 am she pulled the curtain back and saw R3 on his knees and his hand was tangled up into the bed rail. CNA FF stated that R3 could not walk but he could use his hands. CNA FF asked the surveyor if she could demonstrate how R3 was positioned. CNA FF got on her knees and stated that R3 was all the way out of the bed on his knees with his left hand tangled up in the side rail. She stated that once they got him back on the bed they told her to check his vitals. CNA FF stated that R3 was not talking but moaning.Interview with the Maintenance Director on (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 8:44 am revealed that he checked the bedrails last year, but he did not have proof. He stated that the old company took everything with them.A copy of the safe rail spacing and regular inspection of side rails/bed was requested but was not received.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident and staff interviews, record review, and review of facility documents, the facility failed to provide sufficient licensed nursing staff to meet the needs of residents (R) residing on one of two wings, the [NAME] Wing. Specifically, the facility did not have licensed nurse coverage for the [NAME] Wing after 6:00 PM during the 3:00 PM to 11:00 PM shift on December 25, 2025. This deficient practice had the potential to place residents residing on the [NAME] Wing at increased risk of unmet care needs.Findings include:Review of the facility provided document titled [facility name] Daily Staffing, dated December 25, 2025, revealed that the schedule documented no licensed nursing staff listed for the [NAME] Wing for the 3:00 PM to 11:00 PM shift.A review of the facility-provided Grievance/Complaint Report dated 12/26/2026 revealed that DON CCC filed a report stating some residents, who resided on the [NAME] Wing, reported not receiving medication doses at 9:00 PM on 12/25/2025. The report also listed that the Medical Director was notified, and no further orders or interventions were needed at this time.A review of the quarterly Minimum Data Set (MDS) assessment for R6, with an assessment reference date (ARD) of 12/25/2025, revealed that section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 14 (indicating little to no cognitive impairment).A review of the quarterly MDS assessment for R2, with an ARD of 12/26/2025, revealed that section C (Cognitive Patterns) documented a BIMS of 15 (indicating little to no cognitive impairment).A review of the quarterly MDS assessment for R1, with an ARD of 12/17/2025, revealed that section C (Cognitive Patterns) documented a BIMS of 15 (indicating little to no cognitive impairment).In an interview on 01/20/2026 at 1:49 PM, LPN NN stated that she was the Unit Manager for the East Wing. LPN NN stated that she worked on 12/25/2025 on the medication cart for the 7:00 AM to 3:00 PM shift because they had no nurse; she was the only nurse on the East Wing, and she worked until 7:00 PM on 12/25/2025. LPN NN stated that LPN AA and another nurse worked on the [NAME] Wing on the day shift on 12/25/2025. LPN NN stated that the two nurses on the [NAME] Wing left around 6:00 PM. LPN NN stated that LPN AA called her to come and get her facility keys. She stated she informed LPN AA that she was unable to take the keys, as she was working the East Wing. She stated that the two nurses on the [NAME] Wing counted the medication cart with each other, left the keys on the unit at the nurse's station, and left the facility. LPN NN stated that the residents told her the next day that a nurse came in at about 2:00 AM and they did not receive their medications or insulin.In an interview on 1/21/2026 at 9:56 AM, Certified Nursing Assistant (CNA) QQ revealed that she has been in the scheduler position since August 2025. She stated that the facilities used agencies for nursing staffing and that there had been many call-outs with both agencies and with in-house staff. She confirmed that no licensed nurses were assigned to the [NAME] Wing on 12/25/2025 for the 3:00 PM to 11:00 PM shift, and she was unable to fill the assignments with nurses. She further stated that the DON CCC was notified and did not come in to work the shift.In an interview on 01/21/2026 at 10:52 AM, Administrator JJ stated he was unaware that there was no nurse in the [NAME] Wing after 6:00 PM on 12/25/2026.In an interview on 01/21/2026 at 11:02 AM, Regional Nurse Consultant RN BBB confirmed there was no nurse on the [NAME] Wing on 12/25/2025 after 6:00 PM. In an interview on 01/21/2026 at 3:35 PM, LPN AA stated that she worked for a staffing agency, and she worked the 7:00 AM to 3:00 PM shift on 12/25/2025 on the [NAME] Wing. She stated that no one showed up to relieve her at 3:00 PM, and she called the Staffing Scheduler, DON CCC, and Administrator JJ to inform them that a nurse did not show up to relieve her at shift change. She stated that the DON stated there was nothing she could do. LPN AA stated she stayed until almost 6:00 PM, and she and Registered Nurse (RN) BB locked the medication cart keys in the medication storage room and left the facility.In an interview on 01/22/2026 at 2:28 M, LPN AAA stated that she worked the morning of 12/26/2025, but she did not remember who she relieved. She stated that sometimes the nurses arrive late, and she has to count (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the cart with a nurse from another hall. LPN AAA stated that she remembers residents complaining about not receiving their medication because there was no nurse available to give it. In an interview on 01/27/2026 at 11:31 AM, RN BB stated that she started her shift at 11:00 PM on 12/24/2025. She stated that her shift was supposed to end at 3:00 PM, but no one came in to relieve her. RN BB stated that she informed the DON, CCC, and Administrator JJ that she had no relief. She stated that Administrator JJ told her that he would try to find some relief. She stated that she stayed until almost 6:00 PM, counted the medication cart with LPN AA, put her keys in the locked medication room, and left the facility.In an interview on 01/20/2026 at 12:27 PM, R6 stated that on Christmas Day last year, there was no nurse after 3:00 PM to give them their medicine. He stated that there were two nurses during the day, but they left at 6:00 PM.In an interview on 01/21/2026 at 11:29 AM, R2 stated that there was no nurse on the [NAME] Wing on the evening shift on Christmas Day. She stated that there had been a couple of days when no nurse was available, usually around the holidays.In an interview on 01/21/2026 at 11:40 AM, R1 stated that he went out with his family on Christmas Day, and when he returned to the facility around 7:00 PM, there was no nurse working on the [NAME] Wing. He stated that he is a diabetic, and he did not receive any medicine until the next day.