

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2026
NAME OF PROVIDER OR SUPPLIER Rosewood at Tybee Island of Journey Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, resident staff interviews, and record review, the facility failed to maintain a clean and comfortable homelike environment for two of 27 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) related to dirty Packaged Terminal Air Conditioner (PTAC) filters, debris build-up on the floor, unidentified clothing items on the floor, a unknown bagged item stored in the residents room, and a light bulb base hanging from the ceiling bathroom. Findings included: During an observation on 6/5/2026 at 8:42 am, the PTAC Unit in room [ROOM NUMBER] revealed that the PTAC Unit filter contained thick, grayish-colored fuzzy debris. During an observation on 6/5/2026 at 9:17 am and 6/6/2026 at 7:46 am in room [ROOM NUMBER] revealed the PTAC filter obtained a gray thick fuzzy debris, a thick gray substance underneath the PTAC unit with a business card embedded in the debris, a square black item wrapped in a black garbage bag placed next to the bedroom sink, unidentified clear bag containing clothing items, and the light bulb base was hang by wires from the ceiling bathroom. A review of R58's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating little to no cognitive impairment. During an interview on 6/5/2026 at 9:17 am, R58 revealed the black square items placed next to the sink belonged to a resident that was previously occupied the room. He continued to state it had been there for a while, and not sure why it was still in his room. Further, R58 stated the unidentified item placed next to his headboard was not his clothing items, and it has been on his floor for a few days now. Continued with the interview with R58, who revealed he uses his restroom and stated he noticed the hanging light bulb and stated it has been like that for a while. R58 stated that he was not satisfied with the conditions of his room, and he stated that his room is not cleaned on a routine basis. During a walk-through observation and interview on 6/7/2026 at 1:59 pm, the Executive Director (ED) confirmed that the PTAC filters in rooms [ROOM NUMBERS] contained thick gray fuzzy debris on the filters. Continued with the walk-through observation and interview with the ED confirmed room [ROOM NUMBER] had thick gray debris underneath the PTAC unit, room [ROOM NUMBER] light bulb base was hanging from the ceiling, unidentified clothing items in an unclear and unlabeled bag were on the floor next to R58 bedside, and an unknown item covered in a black garbage bag should not be there or needs to be fixed. Lastly, the ED continued to state that his expectations are for daily rounds to be conducted to identify these areas of concern and be addressed by the appropriate department.		

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 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and record review, the facility failed to ensure a vermin-free environment related to an active raccoon infestation within the facility's attic ceilings, main dining room, and walls. This failure placed 82 of 82 residents at substantial and immediate risk for physical injury (scratches/bites) and exposure to infectious vectors and diseases, including rabies. On 6/6/2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Executive Director (ED) and Director of Nursing Services (DNS) were informed of the Immediate Jeopardy (IJ) on 6/6/2026 at 6:17 pm. The noncompliance related to the IJ was identified as having existed on 5/18/2026. An Acceptable Removal Plan was not received at the time of exit on 6/7/2026. Therefore, the IJ status was ongoing. Findings included: 1. A review of the electronic medical record (EMR) revealed that R24 was admitted to the facility on [DATE], with diagnoses including, but not limited to, disorders of muscle, depressive episode, anxiety disorder, insomnia, major depressive disorder, and muscle weakness. A review of R24's Nurse Progress Note dated 5/28/2026 at 6:55 pm revealed an encounter adjustment disorder with mixed anxiety and depressed mood related to stressors (financial, functional, environmental). 2. A review of the EMR revealed that R31 was admitted to the facility on [DATE] with diagnoses including but not limited to muscle weakness, difficulty in walking, and cognitive communication deficit. A review of R31's Nurse Progress Note dated 5/26/2026 at 7:41 pm revealed an encounter Remeron 30 milligrams (mg) at bedtime for insomnia. The recommended nonpharmacological interventions were to maintain a quiet and stress-free environment. During an observation on 6/5/2026 at 10:32 am, there was a hole in the ceiling of R24's room. She indicated that the hole was caused by a raccoon falling through the previously wet ceiling tile and that the incident occurred on Tuesday, 6/2/2026. R24 expressed her concerns about sleeping at night, fearing that another object might fall through. Additionally, R24 presented a photograph showing the raccoon positioned between the wall and the nightstand, with the document dated Tuesday at 6:15 pm. During an interview and observation conducted on 6/5/2026 at 10:44 am, R29 stated that she experiences fear at night due to the sound of something heavy moving in the ceiling. She is concerned that it may collapse through the stained ceiling tiles above her bed. During an interview conducted on 6/5/2026 at 4:20 pm, the Director NN reported that a raccoon had entered through the ceiling. However, she clarified that the raccoon did not fall onto the residents. This incident occurred on 6/4/2026 at 10:43 am. She further confirmed that the raccoon fell onto the floor. The facility has since ordered tiles and traps throughout the premises, and three raccoons were captured and relocated to wildlife. She mentioned that there are several more raccoons in the ceiling, and their presence can be heard. In total, three raccoons were captured from Monday to Thursday. One of the raccoons was discovered in the hallway near the kitchen by a nurse. During an interview on 6/6/2026 at 9:43 am, R24 stated that her primary concern was the prolonged duration taken to repair the hole in the ceiling. During an interview on 6/6/2026 at 9:50 am, the Business Office Director stated that staff were moving about in a state of fear because a raccoon had fallen from the ceiling in the residents' room. She stated that upon entering the room, she noticed the hole, closed the resident's door, took two pillowcases, and used them to capture the raccoon, placing it in a trap until wildlife rescue could retrieve it. She mentioned that the raccoon had fled to the corner of the room and was hiding between the nightstand and the wall. During an interview on 6/6/2026 at 1:33 pm, R31 stated that no one inquired whether she wished to be moved from the room; they primarily communicated with her roommate. During an interview on 6/6/2026 at 1:33 pm, R24 stated that on 6/2/2026, a raccoon had fallen from the ceiling into the room adjacent to her bed. R24 mentioned that the staff tried to remove her from the room but were unable to get the bed through the doorway. R24 stated that she and R31 remained in the room (continued on next page)		

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