

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

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No. 0938-0391

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 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 in 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 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115730
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations, resident and staff interviews, record review, and review of the Administrator and Director of Nursing Job Description, the facility administrations failed to manage the facility in a manner that protects residents' health and safety by failing to identify, remediate, and eliminate a known active raccoon infestation within the facility's attic ceilings, main dining room, and walls. Specifically, administration had documented knowledge of wildlife infestation since 5/19/2026, when staff observed a live raccoon in the ceiling, but failed to implement effective eradication measures or secure the building. This administrative failure placed 82 residents at substantial and immediate risk for physical injury (scratches/bites) and exposure to infectious vectors and diseases, including rabies, resulting in a determination of an ongoing immediate jeopardy. 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: During an observation on 6/5/2026 at 10:32 am, R24 was observed in her room lying in her bed. During an observation of the room, the ceiling tile was observed to have a hole, and pinkish colored insulation was observed bulging through the hole. During an interview with the resident at this time, she stated that the hole was caused by a raccoon falling through the wet ceiling tile. She stated that this incident occurred on Tuesday, 6/2/2026, and pulled up a photo on her cellular phone of a raccoon crouching in the corner between the wall and the nightstand (photo dated and timestamped as Tuesday, 6/2/2026 at 6:15 pm). She stated that she was concerned because they had not fixed the hole, and she feared that something else might fall through the ceiling while she was sleeping. During an observation on 6/5/2026 at 11:02 am, the hallway between the main lobby and the entrance door to the main dining area revealed an opening in the ceiling, with only one ceiling tile positioned to cover the area of two tiles. These ceiling tiles exposed pink-brownish colors of insulation. There were several soiled/saturated brownish colored ceiling tiles surrounding the area, near the main dining area and the east wing. During an interview on 6/6/2026 at 3:06 pm, the Director of Nursing Services (DNS) revealed that she witnessed an incident near the dining room when a raccoon fell from the ceiling. She stated that Registered Nurse (RN) OO and the Certified Medical Assistant (CMA) BB relocate residents. The DNS recounted that while she was walking, the raccoon fell. She reported that she informed the ED. The DNS indicated that she only assessed the resident's room where the raccoon was found but did not conduct interviews with other residents; however, she did speak with one resident outside at that time. She directed RN OO and CMA BB to relocate the resident to another room, but later discovered that they could not move the bed because it would not fit through the door, and the bedrails could not be lowered. The DNS expressed that R3 could have moved her, but there was no available bed for R24 to transfer into. She felt that if R24 was left behind, there was no point in moving the other resident, R31, because the raccoon fell on R24's side of the room. The DNS shared that she visits the resident's room daily and has concerns regarding the exposed hole. The DNS acknowledged the risk posed by the open hole and the potential dangers it presented. During an interview with the ED on 6/6/2026 at 3:31 pm, he revealed that on 5/19/2026, the previous Maintenance Assistant (MA) PP reported the resident hearing noises from the ceiling. Upon further investigation, he ascended a ladder and found a raccoon in the [NAME] Wing. He noted that the DNS (continued on next page)		

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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. Based on observations, staff interviews, review of the facility documents, and review of the facility's policies titled Food Safety Requirements and Ice Machines and Portable Ice Carts, the facility failed to properly discard expired food items and properly store, label, and date them. Additionally, the facility failed to prevent wet nesting and maintain the ice machine in a sanitary condition. These deficiencies posed a potential risk to 79 out of 82 residents who received an oral diet from the kitchen, increasing their vulnerability to foodborne illnesses. Findings included: A review of the facility's policy titled Food Safety Requirements dated February 2025 documented that food would be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines 1. Food safety practices shall be followed throughout the facility's entire food handling process. b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from the growth of microorganisms. A review of the facility's policy titled Ice Machines and Portable Ice Carts, implemented on 11/15/2024, documented that the ice machines/carts can be prone to microbial contamination due to improper handling or storage of ice, poor cleaning or maintenance of equipment, or through ice handling equipment. Proper cleaning, maintenance, and infection control in relation to ice machines are important to decrease the risk of illness to residents, staff, and visitors. Compliance Guidelines 1. Ice machines will be cleaned at a frequency specified by the manufacturer or, if manufacturer specifications are absent, at a frequency necessary to preclude accumulation of soil or mold. 2. The facility will determine the frequency at which the ice machine (interior, exterior, parts, etc.) will be cleaned/ sanitized (i.e., daily, monthly, quarterly, annually, etc.) with documentation to support the cleaning procedures. A review of the Department of Public Health inspection dated 4/30/2026 at 2:30 pm revealed in the Observations and Corrective Actions section 4-2B, observed mold-like build-up on the baffles of the ice machine in the front dining service area. During the kitchen initial tour on 6/5/2026 at 7:44 am, revealed in the dry storage area that one white oversized container with rice, inside rice presented one scoop, on top of a box adjacent to the white containers were four unbagged scoops, three 111 ounces (oz.) beans dented cans located on the active stock shelf. Five packages of 16 oz. enriched macaroni lasagna, with an expiration date of 4/22/2026, and one box containing 10 lbs. of lasagna, with an expiration date of 4/9/2025. Several open, unlabeled, and undated items were observed: two 10-pound (lbs.) bags of penne pasta, one 10 lbs. elbow noodles, one 5 lbs. egg noodles, and one 10 lbs. spaghetti noodles. Confirmed with Dietary Manager (DM). Inside the kitchen, there was one stand-alone reach-in freezer and one double-door reach-in refrigerator positioned side by side, near the stove and steam table. The reach-in freezer was observed and revealed 20 bags of 20-count breadsticks, two repackaged bags of chicken, one 10 lbs. chicken in a blue bag, and one package of repackaged clear-wrapped chicken breast strips, as confirmed by the DM, along with one 12-count pretzels neither labeled nor dated. The reach-in refrigerator contained one 4-quart (qt.) container of boiled eggs that were neither labeled nor dated, one 12 oz. jar of grape jelly, and one square piece of cake on a paper plate that also lacked a label and date. The walk-in freezer revealed four pork chops in a clear repackaged bag that were unlabeled and undated, along with one 5 lb bag of cookie dough. Confirmed by the DM. The ice machine inspection was conducted by the DM, who donned a glove and utilized a white paper napkin to assess the condition of the ice machine. The DM placed the white paper napkin on the inner fold and swiped it across, revealing a brown-like residue. The DM confirmed that the ice machine required cleaning and acknowledged the presence of the brown-like residue on (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the napkin.During an interview on 6/5/2026 at 9:25 am, the Registered Dietitian (RD) confirmed his awareness of all the issues identified during the initial kitchen tour, as well as some additional concerns. The RD explained that the staff has progressed from not labeling and dating to now having some items that are labeled and dated. He emphasized the importance of celebrating small victories. The RD acknowledged that while the kitchen has its challenges and is a hot mess, it is a work in progress.On 6/6/2026 at 11:25 AM, the Regional Nurse Consultant confirmed that there was no ice machine cleaning log.During an observation and interview on 6/7/2026 at 12:26 pm, during the preparation of the lunch meal trays, it was noted that [NAME] II retrieved a stack of plates from the plate warming station to start assembling the residents' trays. After preparing plates and completing one with the lunch meal, it was confirmed that the plates were for use and displayed excessive water along with the served plated meals. The RD confirmed the observation, removed the affected plates from the line, and started using white disposable plates. [NAME] II explained that they usually plug in the plate warmer, and it dries the plates, but they forgot today.During an interview on 6/7/2026 at 12:31 pm, the Dietary Aide (DA) JJ disclosed that she was tasked with plugging in the plate warmer. However, she forgot to do so. She confirmed that all the plates were wet, which posed a risk of infection.During an interview on 6/7/2026 at 12:34 pm, the RD confirmed the wet-prepped plates and stacked wet plates. He revealed that neither he nor the DM conducted an in-service training with the team regarding wet nesting and is aware that the wet plates should not be stacked as it may lead to bacteria growth and cross-contamination.		

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interviews, and a review of the facility policy titled Soiled Linen and Trash Containers, the facility failed to ensure outdoor garbage was secured in safe working conditions and that the refuse area was maintained in a sanitary manner, creating the potential for harboring pests, insects, and rodents. Census 82. Findings included: A review of the facility policy titled Soiled Linen and Trash Containers, reviewed dated 2/16/2024, revealed under Policy Explanation and Compliance Guidelines: 7. Loose trash and linen shall be appropriately bagged before placing into the large storage bins. During the initial observation and interview of the dumpster area on 6/5/2026 at 8:28 am, with the Dietary Manager (DM), revealed two blue dumpsters were open. Upon facing the dumpsters, it was observed that the dumpster positioned on the left had its left door open, while the right dumpster had a broken lid on the left side and exposed trash. Further observation revealed the area was surrounded by discarded bulk furniture and a black wheelbarrow containing trash. The DM confirmed that the dumpsters were open and should be secured, ensuring that no trash was present on the ground or in the surrounding area. The DM also mentioned that the discarded bulk furniture had been present since she began her tenure, approximately two to three months ago. During an observation on 6/6/2026 at 8:23 am, facing the two blue dumpsters, the left dumpster door was open on the left side, whereas the right dumpster had a damaged lid on the left side, which revealed trash placed on top of the broken lid. Additional observations showed that the vicinity was cluttered with abandoned bulk furniture. During an interview on 6/6/2026 at 12:07 pm, the Executive Director (ED) confirmed that the presence of dumpsters is a contributing factor to the issue of raccoons and cats. The ED mentioned that he had observed that the top of the dumpsters was missing/broken. ED explained that the previous company leased equipment to the facility, and it was replaced by new ownership, and the leased bulk furniture was placed outside near the dumpster awaiting pickup. ED expressed that he believes that those items have been outside since 2/1/2026. During an interview on 6/6/2026 at 3:47 pm, Certified Medical Assistant (CMA) BB revealed that raccoons are seen going into the open dumpsters all the time, as recently as 6/2/2026.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of the facility policy titled Laundry, the facility failed to maintain infection control practices related to: (1) resident personal care items not stored properly to prevent cross-contamination; (2) maintaining one of two shower rooms (West Hall) in a sanitary condition; and (3) ensuring that the resident laundry was free of exposure of environment hazardous material and contamination. The deficient practice had the potential to expose residents to infections due to cross-contamination. Findings included: 2. During an observation of the [NAME] Wing Shower Room on 6/5/2026 through 6/7/2026, a soiled washcloth covered with dark substances was sitting on a rack, and a dirty razor was on the bathroom floor. During an observation walk-through tour of the laundry room on 6/7/2026, the Consulting Housekeeping Staff confirmed the sanitation conditions of the shower room. 3. During an initial tour of the facility laundry room on 6/5/2026 at 11:01 am with the Housekeeping Laundry Aide (HK/LA) KK and LL. The following infection control concerns were identified regarding the sanitation of resident clothes in the laundry area: The facility laundry room exterior/interior entrance door (which connects the outside of the building to the inside of the building) did not have a secure, tight fit due to large gaps of wood missing on the side frame, top frame, and bottom frame of the door, allowing accessibility to dust, insects, and rodents. Staff were observed using dirty bed coverings covered with dark brown stains filled with greyish substances and dark stains, which were identified by staff as layers of dirt and dust to prevent the door from opening. Interview and observation with HK/LA KK revealed that since the last survey, the door was identified, and maintenance was supposed to add aluminum frames to the door, but no one followed up on the repairs. She reported that any insects or rodents can enter the door. The laundry staff tries to sweep and monitor for dust and fecal materials from rodents as much as possible. This is hard to do at times. The blanket is used to hold the door closed, but does not cover all the cracks at the top, sides, and bottoms. The laundry room flooring was observed to be dirty, soiled wet bed linen covering, and towels used for water leakage on the floor throughout the laundry room, one blanket was placed in front of the washer, and other areas near clean and dirty clothes bins. An interview was conducted with HK/LA KK. She reported that due to water puddles coming from the floor structures and washers, the blankets and towels were being used to dry up the water. A large commercial fan sitting on the floor, blowing directly towards the resident's clothes area, revealed the blades of the fan and frame of the fan coated with thick dark greyish substances with dark black speckled substances. An interview was conducted with HK/LA KK, and she described the substances as dust and dirt. The wall-mounted washer chemical dispenser revealed that the pumps were not attached. During an interview at this time, HK/LA KK reported that the dispenser pumps had been detached from the wall mount for almost a year and a half. She was instructed to use a measuring cup to pour the detergent (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	into the washer from the large gallon containers. She was not sure of the correct measuring device for how much chemical to use. It was based on her estimation and not the manufacturer's guidance. She reported that the previous Administrator had instructed her to just use the measuring cup. During a tour of the facility laundry room with the Administrator on 6/5/2026 at 11:38 am, the Administrator reported being unaware of the laundry room door and the sanitation condition of the laundry room, including the commercial washer chemical dispenser needing repairs. The Administrator verified that the laundry room door was unable to be secured due to large opening gaps at the top of the door, the side of the door, and the bottom of door was an infection control concern due to residents' clothes being accessible to rodents and dust. He reported that the plan is to have the chemical pump looked at, repaired, the fan cleaned, to cover the gaps in the door, and to possibly order a new door in the future. During an observational tour of the facility laundry room on 6/7/2026 at 10:12 am, Administrator B (an administrator from a sister facility) confirmed that all identified needed repairs and the sanitation of the facility laundry room continued to exist (door with large gaps, chemical wall-mounted pump system, dirty fan, and wet blankets and towels remaining on the floor). A review of the facility policy titled Laundry dated 2/1/2024 stated the facility launders linens and clothing in accordance with current CDC guidelines to prevent transmission of pathogens. If using fans in laundry processing areas, prevent cross-contamination of clean linens from air blowing from soiled processing areas (i.e., the ventilation should not flow from soiled processing areas to clean laundry areas). 1. A basic infection control policy was requested but was not received. During observations on 6/5/2026 at 10:07 am, 6/6/2026 at 8:02 am, and 6/7/2026 at 11:40 am of the bathroom in room [ROOM NUMBER], a brown smeared substance was observed on the bathroom floor in front of the toilet. The observation also included a shelf above the toilet with two urinals resting inside a bedpan and two additional urinals and one bedpan resting on the shelf. Neither the bedpans nor the urinals were labeled or bagged. During an interview on 6/7/2026 at 11:42 am, the Director of Nursing Services (DNS) confirmed through observation that the urinals and bedpans resting on the shelf above the toilet needed to be bagged and labeled to eliminate the spread of infection. The DNS confirmed the brown smeared substance located in front of the toilet in the bathroom of room [ROOM NUMBER] needed to be removed/cleaned immediately.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, staff interview, record view, and a review of the facility policy titled Safe Water Temperature, the facility failed to maintain safe water temperatures in eight of 43 Residents' Rooms (RM) (RM 204, RM [ROOM NUMBER], RM [ROOM NUMBER], RM [ROOM NUMBER], RM [ROOM NUMBER], RM [ROOM NUMBER], RM [ROOM NUMBER], and RM [ROOM NUMBER]) and one of two common-use shower rooms. Findings included: A review of the facility policy titled Safe Water Temperatures, revised on 2/16/2024, revealed that it is the policy of this facility to maintain appropriate water temperatures in resident care areas. Staff will be educated on safe water temperatures upon employment and on a regular basis. Thermometers will be available as needed for use by all staff. Staff will report abnormal findings, such as complaints of water is too cold or hot, burns or redness, or any problems with water temperature (ex. water is painful to touch or causes redness), to the supervisor and/or maintenance staff. Water temperatures will be set to a temperature of no more than 120 F (Fahrenheit) or the state's allowable maximum water temperature. Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed. Documentation of testing will be maintained for three years and kept in the maintenance office. During observations on 6/5/2026 from 9:01 am to 9:33 am, the residents' rooms in the [NAME] Wing were observed. When checking the water temperature in the sinks, the water was uncomfortably hot to the hand and could not be run over the bare skin for more than ten seconds. This was observed in resident rooms 204, 206, 123, 208, 210, 209, 211, 211, and 212, and the [NAME] Wing Shower Room (shower sprinkler head and sink) was uncomfortably hot to the touch and could not be run over bare skin for more than 10 seconds. During an environmental tour of the facility with the Housekeeping Floor Technician beginning on 6/5/2026 at 10:01 am and ending at 10:25 am, water temperatures were taken using a digital water thermometer with the water running from the faucets (of the room sinks (photographic evidence)). During an observation of the water temperature taken in the resident rooms located on the [NAME] Wing and the [NAME] Wing shower room between 10:00 am and 10:32 am on 6/5/2026, the following: At 10:01 am, the water in room [ROOM NUMBER] (sink) was 122.5 degrees F. At 10:04 am, the water in room [ROOM NUMBER] (sink) was 122.3 degrees F. At 10:10 am, the water in room [ROOM NUMBER] (sink) was 123.2 degrees F. At 10:11 am, the water in room [ROOM NUMBER] (sink) was 122.0 degrees F. At 10:13 am, the water in room [ROOM NUMBER] (sink) was 121.2 degrees F. At 10:14 am, the water in room [ROOM NUMBER] (sink) was 120.0 degrees F. At 10:16 am, the water in room [ROOM NUMBER] (sink) was 121.8 degrees F. At 10:22 am, the water in room [ROOM NUMBER] (sink) was 120.2 degrees F. At 10:25 am, the water in the [NAME] Wing shower room was observed: The sink was observed at 121.2 degrees F, and the shower was observed at 123 degrees F. The following vulnerable residents were identified as being at potential risk of hot water burns associated with the rooms identified for hot water temperatures: A review of the electronic medical record (EMR) for R10 revealed a diagnosis of dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R10 had a Brief Interview Mental Status (BIMS) score of 10, indicating severe cognitive impairment, and that R10 was ambulatory with a walker. A review of the EMR for R28 revealed a diagnosis of Alzheimer's Disease. The quarterly MDS assessment dated [DATE] revealed that R28 had a BIMS score of six, indicating moderate cognitive impairment, and that R28 was ambulatory. A review of the EMR for R30 revealed a diagnosis of schizoaffective disorder and bipolar disorder. The (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly MDS assessment dated [DATE] for R30 revealed that R30 had a BIMS score of six, indicating moderate cognitive impairment, and that R30 was non-ambulatory but able to self-propel in a wheelchair. A review of the EMR for R69 revealed a diagnosis of cognitive impairment. The quarterly MDS assessment dated [DATE] revealed that R69 had a BIMS score of six, indicating moderate cognitive impairment, and was ambulatory. During the process of taking the water temperatures, an interview was conducted with the Housekeeper Floor Technician on 6/5/2026 at 10:44 am. The Housekeeper Floor Technician reported that the facility no longer had an active Maintenance Worker or a Maintenance Department. He reported that the Executive Director (ED) had instructed him to perform the water temperatures of the identified rooms for hot water with the surveyor team. He reported being aware of regulations related to water temperature based on his former job as a Maintenance Director at another facility. He reported that the safe temperature (parameter ranges) should be maintained no higher than 110 degrees F and no higher than 120 degrees F to prevent burns or injuries. However, he reported that he was not responsible for taking the hot water temperature, and his job duties were as a Housekeeper Floor Technician. He reported that his knowledge of water temperature was from his previous job as a Maintenance Director at another facility. He could not say why the temperatures were varying like they were from room to room, but since the temperatures were above 120 degrees F, he planned to check the gauges on the boiler and would attempt to lower the temperature by using the mixer. Once the adjustment was made, he planned on waiting for 15-30 minutes before rechecking the temperatures in the residents' rooms. During an interview on 6/5/2026 at 10:55 am, the ED confirmed the situation with the hot water temperatures. He reported being unaware of the elevated hot water temperatures at the sink in the resident's room. The maintenance director and the maintenance assistant were no longer employed by the facility. Reported that at this time, the facility did not have any maintenance workers and was working to fix the problem. Staff would be notified and advised not to use the hot water in the resident sink and to ask for staff assistance if there was a need for hot water. The administrator reported not being aware of any incidents wherein a resident, staff, or visitor had been burned or scalded by the hot water in the building. During an interview on 6/7/2026 at 12:12 pm, the ED on 6/5/2026 at 12:12 pm reported that they were unable to access the water temperature logs due to being unable to obtain access to the electronic maintenance system and locate the maintenance director's log book. The maintenance director was last employed on 4/28/2026. The ED reported that he had been employed with the facility for only four weeks and had no record of whether hot water temperatures were being taken by other facility staff for the resident's rooms and showers.		

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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** Based on resident and staff interviews, record review, and review of the facility's policy titled Advance Directives, the facility failed to provide two of three residents (R) (R49 and R58) written information with options regarding their right to accept or refuse medical or surgical treatment and failed to ensure a physician's order matching the resident's documented wishes was established and maintained in the medical record. This failure denied the residents the opportunity to have choices and preferences with their health care decisions and to formulate an Advance Directive, and placed the residents at risk for receiving or not receiving unwanted cardiopulmonary resuscitation in a medical emergency. Findings included: A review of the undated policy titled Advance Directives, under the Policy Interpretation and Implementation, it was documented that Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions about medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. 9. The Director of Nursing Services (DNS) or designee will notify the Attending Physician of advance directives so that the appropriate orders can be documented in the resident's medical record and plan of care. Further, it was documented in the section Documentation/Obtaining Copy of Advance Directive that, should the resident indicate that he or she issued an advance directive about his or her care and treatment, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident's medical record. 1. A review of R49's admission Packet revealed it did not contain language that pertained to the facility's provision of written information about the resident/representative's right to accept or refuse medical or surgical treatment. A review of the electronic medical record (EMR) revealed R49 was admitted to the facility on [DATE] with diagnoses not limited to heart failure, unspecified, chronic obstructive pulmonary disease, unspecified, and acute and chronic respiratory failure, unspecified, whether with hypoxia or hypercapnia. A review of the quarterly Minimums Data Set (MDS) assessment dated [DATE] revealed R49 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. Further review of the medical record revealed, under the Orders tab, an active Physician Order dated 1/30/2026 for a full code. Record review revealed a Physician Orders for Life Sustaining Treatment (POLST) for a Do Not Resuscitate (DNR) dated 5/12/2026. A review of the care plan for R49 revised 2/25/2026 revealed a focus of Advance Directive Full Code with interventions including, but not limited to, In the event of a code call 911 and begin CPR (Cardiopulmonary resuscitation), Date Initiated: 2/13/2026; Honor code status wishes, Date Initiated: (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/13/2026; In the event of cardiac arrest, initiate CPR, Date Initiated: 2/13/2026; Keep family informed of change in condition, Date Initiated: 2/13/2026; and Review code status quarterly and PRN (as needed). Date Initiated: 2/13/2026. During an interview on 6/6/2026 at 8:00 am, R49 confirmed she wanted to be a DNR. She stated she was her own representative. She stated she did not remember receiving anything or signing anything in regard to an advance directive check that let her know her rights to formulate an advance directive or to accept or deny medical/surgical treatment. During an interview on 6/7/2026 at 10:03 am, the facility's admission Coordinator confirmed no evidence was found to support that the resident had been provided with written information related to their right to accept or refuse medical or surgical treatment on or after admission to the facility. During an interview on 6/7/2026 at 10:50 am, the DNS confirmed the resident had an active physician order for a full code. She verified that the resident had a POLST signed for a DNR on 5/12/2026. She revealed that the existing order for a full code should have been discontinued on 5/12/2026 and a new order for a DNR should have been entered under the orders tab. 2. A review of the EMR for R58 revealed he was admitted to the facility on [DATE] with a diagnosis including, but not limited to, type two diabetes mellitus without complications, acute bronchitis (inflammation of the bronchial tubes that carry air to the lungs), and dysphagia oropharyngeal phase (difficulty transferring food from the mouth to the esophagus). A review of R58's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, indicating little to no cognitive impairment. A review of the physicians' orders for R58 revealed there was no order for a code status. A review of the care plan revealed that the top banner on the document titled special instructions was documented as DNR. However, R58 care plan documented resident has physician's orders that include a status of full code with interventions to ensure full code order on chart and ensure staff is aware of code status through designated systems. A review of the EMR banner titled Special Instructions for R58 revealed code status as DNR. A review of the EMR under the contact tab revealed R58 was documented as his own responsible party. A review of the POLST for R58 revealed he is documented as attempting CPR with R58's signature dated 2/21/2025. A review of the admission Records in the advance directive section for R58 was documented as DNR. A review of the admission Agreement revealed that there is no documentation acknowledging DNR code status. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the DNR Book for the [NAME] Wing revealed R58 name is on the DNR list. A review of the code status list revealed R58 is documented as a full code. During an interview on 6/6/2026 at 8:12 am, R58 revealed he signed himself as a full code during his admissions process. He confirmed that the POLST form provided by the facility staff was incorrect and was not the document he signed. During an interview on 6/7/2026 at 9:45 am with the AD, the Social Worker is responsible for the code status during the resident admission process. The AD confirmed that on 2/21/2025, R58 was documented as full-code status. During an interview on 6/7/2026 at 10:25 am, the MDS Coordinator confirmed R58 EMR is documented as a DNR, and he is a full code; there is no physician's order for a code status, and there is a mix-up with documentation with the POLST because the DNR is for R58's family member who is next door at the sister facility. During an interview on 6/7/2026 at 10:51 am, the DON confirmed in R58's EMR system that he is coded as a DNR. The DON further stated on the banner in the EMR under the special instructions acts as the physician's order. Further, the DON confirmed the code status is inaccurate throughout R58's EMR. [Cross-Reference F657]		

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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.		

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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	
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and a review of facility policy titled Discharge Planning Process, the facility failed to ensure residents were not inappropriately transferred or discharged against the resident's/residents' representative's wishes for one resident of 82 sampled residents (R)(R85). Findings included:A review of the facility's policy titled Discharge Planning Process, dated 3/20/2025, revealed that an active individualized discharge care plan will address, at a minimum: Discharge destination, with assurances that the destination meets the resident's health/safety needs and preferences. The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record. A review of 85's electronic medical record (EMR) revealed R85 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic kidney disease, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, type 2 diabetes mellitus without complications, mood disturbance, and anxiety. R85 census indicated that R85 was discharged on 5/1/2026. A review of the R85's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R85 had a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicates severe cognitive impairment, and R85 required substantial/ maximal assistance with toilet, supervision, or touching assistance for bathing. He required a manual wheelchair for mobility. A review of R85's progress notes dated 5/1/2026 revealed an order for Hydrocodone-Acetaminophen Oral Tablet 5-325 milligrams (MG); give one tablet by mouth every six hours as needed for pain 5-10. There was no documentation of a transfer/discharge summary in the electronic health record. There was no documentation that the transfer/discharge is documented in the R85's medical record and that appropriate information is communicated to the receiving health care institution or provider. There was no documentation for the basis for the transfer/discharge. There was no documentation of the R85's status at the time of discharge. There was no documentation that the physician or ombudsman was notified of the transfer/discharge. During an interview on 6/7/2026 at 11:05 am, the Director of Nursing Services (DNS) revealed that R85 was at another facility (a sister facility). She stated that she started in April 2026, and before she was hired, she was told that he was trying to go out the door. She stated that he has a skin assessment at the sister facility. During an interview on 6/7/2026 at 2:10 pm, the DNS further revealed that there are no progress notes of R85's transfer. She stated that the charge nurse was responsible for the documentation and that it wasn't documented because the nurses felt like he was going across the street, so they did not document that he went across the street. The DNS stated that she felt like, since it was one building, they did not need to document the transfer/discharge. The DNS stated that she was not sure if the ombudsman was notified of the discharge/transfer. She stated that she did not notify the ombudsman of the transfer, but she would find out and get back to the surveyor if someone else notified the ombudsman.		

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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, record reviews, and the facility policy titled Resident Assessment-Coordination with PASARR Program, the facility failed to ensure submission to the state-designated authority for a Preadmission Screening and Resident Review (PASARR) Level II for two of two residents (R) (R4 and R29) reviewed for PASARR. This deficient practice increased the potential to place R4 and R29 at risk of not receiving services and/or care according to their needs. Findings included: A review of the facility's policy titled Resident Assessment-Coordination with PASARR Program, dated 12/24/2023, documented that PASARR Level I initial pre-screening is completed prior to admission. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A record of the pre-screening shall be maintained in the resident's medical record. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD (mental disorder), ID (intellectual disability), or a related condition to the appropriate state-designated authority for a Level II PASARR evaluation and determination. The Level II resident must be completed within 40 calendar days of admission. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 1. A review of the electronic medical record (EMR) revealed that R4 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder, bipolar disorder, schizophrenia, and depression. A review of the annual Minimum Data Set (MDS) assessment for R4, dated 4/30/2026, documented that R4 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition and presented with active diagnoses of anxiety disorder, depression, and schizophrenia. A review of the PASARR Level I Assessment for R4, dated 4/18/2024, revealed that the diagnoses of schizophrenia, bipolar disorder, and anxiety disorder were not marked. A review of the clinical record for R4 revealed no submissions for a PASARR Level II after admission. During an interview conducted on 6/7/2026 at 10:11 am, the admission Coordinator stated she is responsible for completing PASARR Level II screenings for residents. She reported that the resident's diagnosis was major depression and indicated that this diagnosis does not qualify for PASARR Level II services. The surveyor asked the admission Coordinator to review the resident's diagnoses after observing a diagnosis of schizophrenia documented at admission. Upon reviewing the resident's EMR, the admission Coordinator confirmed the resident had a documented schizophrenia diagnosis at admission and that schizophrenia is a qualifying diagnosis for PASARR Level II services. She stated she would complete the PASARR Level II assessment immediately. 2. A review of R29's EMR revealed that she was admitted to the facility on [DATE] with diagnoses including, but not limited to, cognitive communication deficit, Schizophrenia Disorder, bipolar disorder, (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and hypertension. A review of the quarterly MDS assessment dated [DATE] revealed that R29 presented with a BIMS score of 12, moderate cognitive impairment. A review of the Care Plans for R29 revealed a care plan dated 4/24/2026. Focus: the resident has a psychosocial well-being problem r/t having little interest or pleasure in doing things. Interventions: Initiate referrals as needed or increase social relationships. During a record review of the undated PASARR Level II list of residents provided by the facility, revealed R29 was not listed. A record Review of PASARR Level I dated 9/6/2024 revealed approval with the physician's signature. PASARR Level II dated 6/7/2026 revealed pending. During an interview on 6/5/2026 at 10:44 am, R29 expressed that she feels isolated. R29 mentioned, I feel like I am going to go crazy, no one talks to me. During an interview on 6/6/2026 at 9:45 am, an interview was conducted with the Social Service Director (SSD). During this meeting, the PASARR binder was reviewed, and it was confirmed that the SSD does not possess the PASARR Level II for R29. It was also confirmed that she has the PASARR Level I documentation available upon admission, and it is possible that the admission Coordinator may have the required information. During an interview on 6/6/2026, at 10:03 am, with the admission Coordinator indicated that she has never submitted a PASARR Level II for the diagnosis associated with R29. The admission Coordinator reviewed R29's diagnosis and confirmed that she was admitted to the facility in 2024 and has never displayed behaviors that would suggest a need for a submission. A follow-up interview with the admission Coordinator at 1:32 pm revealed that while there was a previous Social Worker, the new social worker is unfamiliar with the process of submitting PASSAR applications; with her previous experience, she is now responsible for completing the PASSAR's. The admission Coordinator confirmed that she was never informed by the psychiatric staff or nursing staff that R29 required a PASSAR Level II. She acknowledged that she overlooked this submission. AC emphasized that if you look at R29, there is no need for a PASSAR Level II, as there are no exhibited behaviors.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled Comprehensive Care Plans, the facility failed to revise the care plan for two of 32 sampled residents (R58 and R49) related to the residents' advance directive. This failure placed residents at risk of not having their end-of-life wishes honored. Findings included: A review of the facility's policy titled Comprehensive Care Plan with a revision dated of [DATE] documented under the Policy stated it is the policy of the develop and implement a comprehensive person-center care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychological needs and all are identified in the resident's comprehensive assessment and meet professional standards of quality. (5) the comprehensive care plan will be received and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 1. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R58 presented with a Brief Interview for Mental Status (BIMS) score of 14, indicating little to no cognitive impairment. A review of the care plan revealed that the top banner on the document titled special instructions was documented as (Do Not Resuscitate) DNR. However, R58 care plan documented resident has physician's orders that include a status of full code with interventions to ensure full code order on chart and ensure staff is aware of code status through designated systems. During an interview on [DATE] at 10:25 am with the MDS Coordinator, confirmed R58 electronic medical record (EMR) was inaccurate. She stated R58's Physicians' Orders for Life-Sustaining Treatment (POLST) is a full code. However, the profile banner on the EMR and the care plan banner state R58 is a DNR. The MDS Coordinator continued to state that it is the responsibility of any staff member to update the care plan at any time. 2. A review revealed R49 was admitted to the facility on [DATE] with diagnoses included, but not limited to, heart failure, chronic obstructive pulmonary disease, and acute and chronic respiratory failure with hypoxia or hypercapnia. A review of the quarterly MDS assessment dated [DATE] revealed R49 had a BIMS score of nine, which indicated moderate cognitive impairment. A review of the medical record revealed an active Physician Order dated [DATE] for a full code and a POLST for a DNR order dated [DATE]. A review of the care plan for R59 revised [DATE] revealed a focus on Advance Directive Full Code with interventions including, but not limited to, In the event of a code call 911 and begin CPR, date initiated [DATE]; honor code status wishes, date initiated [DATE]; in the event of cardiac arrest, (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiate CPR, date initiated [DATE]; keep family informed of change in condition, date initiated [DATE]; and review code status quarterly and PRN (as needed) date initiated [DATE]. During an interview on [DATE] at 10:24 am, the MDS Coordinator confirmed R49's current active physician order for a full code order, a POLST for DNR dated [DATE], and a care plan for a full code. The MDS Coordinator confirmed the care plan should have been updated once the code status changed. She revealed that the code status change was not communicated to her and therefore the care plan was not revised to reflect the resident's life code status of DNR. During an interview on [DATE] at 10:50 am, the Director of Nursing Services (DNS) verified and confirmed that R49 had a current active physician order indicating Full Code status, a POLST dated [DATE] indicating DNR, and a care plan reflecting Full Code status. The DNS stated that the MDS Coordinator is responsible for updating and revising resident care plans. The DNS further explained that resident status changes are discussed during clinical meetings, stand-down meetings, and risk management meetings. According to the DNS, care plans are updated and revised in real time during these meetings as changes are identified and discussed. The DNS confirmed the physician order should match the life code status listed in the care plan and stated she would fix all documentation to match the R49's preference of DNR.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to address pharmacy recommendations for a gradual dose reduction (GDR) for one of five residents (R) (81). Findings included: A review of R81's electronic medical record (EMR) revealed that she had diagnoses including, but not limited to, major depressive disorder, recurrent anxiety disorder, chronic obstructive pulmonary disease with (acute) exacerbation, and chronic obstructive pulmonary disease. A review of R81's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R81 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates cognitively intact, and was receiving an antianxiety, anticoagulant, opioid, and antidepressant drug all seven days of the assessment period. A review of R81's March 2026 Physician's Orders revealed an order for Buspirone hydrochloride (HCl) Oral Tablet 5 milligrams (MG). Give one tablet by mouth two times a day for anxiety. A review of R81's April 2026 Physician's Orders revealed an order for Buspirone HCl Oral Tablet 5 MG. Give one tablet by mouth two times a day for anxiety. A review of R81's May 2026 Physician's Orders revealed an order for Buspirone HCl Oral Tablet 5 MG. Give one tablet by mouth two times a day for anxiety. A review of R81's June 2026 Physician's Orders revealed an order for Buspirone HCl Oral Tablet 5 MG. Give one tablet by mouth two times a day for anxiety. A review of the last attempted Gradual Dose Reduction (GDR) for R81 was dated 3/22/2026, noting that the current order is Trazodone 50 MG every night at bedtime (QHS) and Buspirone 5 mg twice a day (BID). A review of the Consultant Pharmacist Consultation Report for R81's dated 3/22/2026 revealed the following: Comment: R81 has received trazodone 50 mg QHS and Buspirone 5 mg BID, which are in the timeline for review for a dose reduction. Recommendation: Please attempt a gradual dose reduction (GDR) to Buspirone 5 mg daily and then discontinue if appropriate. Physician's response: I accept the recommendation(s) above with the following modification (s): trazodone 25 MG by mouth (PO) QHS for two weeks, then stop. Signed and dated by the Medical Director on 4/2/2026. A review of R81's March, April, May, and June 2026 Medication Administration Record (MAR) revealed an order for Buspirone 5 mg BID with a check mark by each date and time indicating the medication was administered. Review of R81's March, April, May, and June 2026 MAR revealed R81 received Buspirone 5 mg BID. During an interview on 6/7/2026 at 2:01 pm, the Director of Nursing Services (DNS) stated that she was not there in March 2026 and that she was not aware of the pharmacy recommendation on 3/22/2026. The DNS stated that she was responsible for monitoring and following up with the GDRs.		