STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115463	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbury Center of McDonough for Nursing & Healing	198 Hampton Street McDonough, GA 30253

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy titled, Safe and Homelike Environment, the facility failed to ensure the environment was homelike, i.e. clean and comfortable, for five residents (R) (R42, R79, R80, R84, R122) attending the resident council interview, for 14 residents residing on the [NAME] Unit in rooms R32, R33, R34, R40, R45, R47, and R48 and for all 44 residents residing on the Heritage Unit and for one resident (R400) residing on the Memory Care Unit out of a total census of 143 residents. Findings include: Review of the facility's Safe and Homelike Environment policy dated 4/2025 and provided by the facility revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . A homelike environment is one that de-emphasizes the institutional character of the setting . Orderly is defined as an uncluttered physical environment that is neat and well-kept . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment . During an observation on 6/23/2025 at 12:02 PM, R36's room was observed. There were crumbs strewn across the floor on both sides of the room. R36 stated his bathroom was unclean and in a state of disrepair. R36 stated the toilet was very difficult to flush and this had been reported multiple times, the toilet seat was loose, and the toilet cover was cracked. The bathroom was observed at this time and the flooring around the toilet was soiled with accumulated black residue and the top of the commode seat had two large brown streaks on it. The surveyor pushed the handle down to flush the toilet and it was very difficult to push the handle down. R36 stated he told staff on a daily basis about the toilet being difficult to flush but it had not been fixed. The toilet seat was observed to be loose and rocked back and forth when tested. There was a rust-colored substance on the toilet seat several inches long and a couple inches wide on both sides of the seat. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the resident council interview on 6/24/2025 at 2:33 PM, R80 and R84 stated housekeeping was inconsistent and their rooms did not always get cleaned. They stated housekeeping had a lot of staff turnover and there were less housekeepers on the weekends. R80, R84, and R122 stated when this occurred, their garbage cans overflowed, their rooms were not cleaned, and they ran out of toilet paper and paper towels. In addition, R79 stated repairs were not always made timely by maintenance. R79 stated his toilet clogged up recently and he had complained about it for three weeks before it was repaired. R42 stated her toilet was also stopped up and not working at the same time. R79 stated one of the shower heads had minimal pressure and dribbled. R84 stated the shower room was unpleasant as it was cluttered with lots of equipment stored there. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/28/2025 revealed R80's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating R80's cognition was intact. Review of the Annual MDS with an ARD of 6/10/2025 revealed R84's BIMS score was 15, indicating R84's cognition was intact. Review of the Quarterly MDS with an ARD of 5/01/2025 revealed R122's BIMS score was 15, indicating R122's cognition was intact. Review of the Quarterly MDS with an ARD of 6/12/2025 revealed R42's BIMS score was 14, indicating R42's cognition was intact. Review of the Quarterly MDS with an ARD of 3/27/2025 revealed R42's BIMS score was 14, indicating R79's cognition was intact. Review of the Quarterly MDS with an ARD 4/22/2025 revealed R36's BIMS score was 12, indicating R36's cognition was moderately impaired (score of 8 - 12). Resident Council Minutes documented concerns with the environment as follows: a. Review of Resident Council Minutes dated 11/26/2025 revealed, Housekeeping is not sweeping the floor. b. Review of Resident Council Minutes dated 12/19/2024 revealed, Outside windows need cleaning . Resident stated they need more trash bags and can in rooms. c. Review of Resident Council Minutes date 1/29/2025 revealed, Need floor mopped d. Review of Resident Council Minutes dated 2/20/2025 revealed, wants room stripped (floor) . light above bed keeps going out. e. Review of Resident Council Minutes dated 3/27/2025 revealed, bathroom toilet keeps stopping up. f. Review of Resident Council Minutes dated 4/29/2025 revealed, We need more tissue in rooms . Shower head maintenance issue . Tissue we only have two rolls in rooms . Only getting room cleaned three times a week . Shower head is broke [sic] on [NAME]/[NAME]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/25/2025 at 9:05 AM in room [ROOM NUMBER]B the ceiling tiles directly above the bed had an accumulation of dust. Several ceiling tiles were askew creating a gap where a thick layer of dust had accumulated. The ceiling in the bathroom had areas of discoloration/leaks. Observations in the bathroom revealed an area four inches in diameter with a black fuzzy substance on the ceiling tile. In addition, there was a second area the same size on a different ceiling tile that was discolored with a brown colored area. During an observation on 6/25/2025 at 3:12 PM, the MD and ES2 verified the difficulty flushing the toilet (the MD adjusted the handle and fixed it), the presence of brown streaks on the toilet seat, the cracked plastic, and black substance on the floor. The MD and ES2 stated they had not been aware of the issues in the bathroom. Observations revealed concerns in residents' rooms: During an observation on 6/26/2025 at 8:52 AM room [ROOM NUMBER]A was observed with water on the floor with base board peeling away from the wall underneath the window where bed B was located. There was a small puddle of water observed on the floor in the area where the base board was peeling away from the wall. During an observation on 6/26/2025 at 8:57 AM, the linoleum floor in room [ROOM NUMBER] was soiled with a black substance around and on the floor tiles for two feet at the entry to the room, where the hallway flooring and the room flooring met. Additional rooms on this hallway revealed the same discolored, blackened areas in rooms 32, 33, 34, 45, 47 and 48. Observation, on 6/26/2025 at 11:50 AM of the hallway and area near the locked door to the MCU, revealed the vinyl base boards looked soiled. Part of a vinyl baseboard was missing on one side of the door and a piece of wood (painted white) that did not match the other baseboards was in place. The brick wall just above the baseboards had a gray discoloration that looked like dust buildup. There were several floor tiles with missing pieces, and other tiles were stained with a yellow/brown discoloration. On 6/26/2025 at 2:30 PM, the [NAME] shower room was observed with missing tiles in the shower, 15 small tiles and several larger tiles. There was an area of several inches on the grout that was black and the MD stated scraping it would not remove the substance. There was a section of base board that was missing. On 6/26/2025 at 2:36 PM, the [NAME] shower room was observed. There were multiple pieces of equipment stored in the room, taking up 50% of the space including two Geri chairs, four mechanical lifts, and a wheelchair. The space was cluttered. The MD and ES2 verified these observations and that the shower was being used as a regular storage area for equipment. On 6/26/2025 at 2:40 PM, [NAME] shower room revealed one of the three shower heads was broken. There were three mechanical lifts stored in the bathroom presenting a cluttered appearance. There were two of three light bulbs that were burned out in the light fixture. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/2025 at 2:44 PM, the Heritage shower room revealed several large, tiled areas on the floor and walls that were missing tiles. There was a black substance along the entire baseboard trim and flooring in both of the two shower stalls and the MD stated it was mildew. The ceiling tiles and light fixtures above the tub were discolored brown and none of the fluorescent lights in this area worked. There was a section of baseboard trim approximately two feet in length that was peeling away from the wall; it was affixed to the wall with tape. The MD stated this bathroom needed the most attention. During an observation on 6/26/2025 at 2:50 PM with the Maintenance Director (MD) and regional manager, Environmental Services (ES)2, the MD stated the water that accumulated on the floor in the room was due to the resident in Bed B who routinely spilled water from a jug on the floor and that was why it was wet. During an observation on 6/26/2025 at 2:50 PM with the MD and ES2, the MD and ES2 walked down the hallway with the surveyor and verified that rooms 32, 33, 34, 40, 45, 47, and 48 had black substance on the floors in residents' rooms where the entry and hallway met. The MD and ES2 verified the accumulated black substance on the floors in residents' rooms on the [NAME] hall. ES2 stated the floors had not been cleaned properly previously and there was accumulated grime that was not easily removed. ES2 stated the floors would have to be completely stripped and then waxed. During an observation on 6/26/2025 at 3:07 PM in room [ROOM NUMBER], the MD verified the presence of the dust in ceiling panels above the bed and stated it needed to be cleaned. The MD entered the bathroom and observed the two areas on the ceiling (black fuzzy substance and brown area) and stated the facility had an issue with the roof and had recently done some repairs; however, there were still some areas of concern. During an interview on 6/26/2025 at 3:36 PM, MD and ES2 stated the Geri chairs and mechanical lifts were stored in the shower rooms because there was no place else to store them. Review of the face sheet for Resident(R) 400, revealed the facility admitted the resident on 6/20/2025 with diagnoses of coronary artery disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), End Stage Renal Disease (ESRD) with need for Hemodialysis, Diabetes, and Dementia. During an interview on 6/27/2025 at 10:27 AM, Housekeeper (HK)1 and HK3 were interviewed together. HK1 stated she had been employed for three weeks and HK3 for five days. They stated their routine included cleaning some of the common areas when the first came on shift at 8:00 AM and then started cleaning residents' rooms around 10:20 AM. They stated the remainder of their shift was spent cleaning each resident's room in their respective areas. HK1 stated she was responsible for 24 - 26 resident rooms and HK3 stated she had 30 - 35 rooms. Cleaning rooms consisted of dusting, sweeping, mopping, emptying garbage, filling toilet paper and paper towel dispensers, and sanitizing surfaces. They stated the mechanical lifts and Geri chairs were routinely stored in the shower rooms. They stated the black gunk of the floors on the [NAME] unit was permanent; mopping it did not remove the black soiled areas. During an interview on 6/27/2025 at 2:59 PM, the Administrator stated the floors in residents' rooms on [NAME] where the linoleum met the hallway looked terrible. The Administrator stated improvement was needed.

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F 0600 Level of Harm - Actual harm 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 observation, interview, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to protect four of 19 residents (R) (R200, R60, R66, and R73) right to be free from physical abuse by R154 and R160. Specifically, the facility failed to ensure R60 was free from physical abuse by R160 resulting in scratches on the face and R154's abuse towards R66 that resulted in actual harm when she sustained a sprained ankle and required an emergency room (ER) visit where an ankle immobilizer was initiated. R154's abuse towards R73 resulted in psychosocial harm using the reasonable person concept when dragged and pinned to the floor by R154. Findings include: Review of the facility's Abuse, Neglect, and Exploitation, policy dated 4/2024 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 Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . 1. Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R154 was admitted to the facility on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies and dementia. R154 was discharged on 4/1/2025; his closed record was reviewed. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/2024 in the EMR under the MDS tab revealed R154 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) of four out of 15 indicating severe cognitive impairment. R154 required supervision or partial/moderate assistance with most activities of daily living (ADLS). R154 exhibited physical behaviors toward others and verbal behaviors towards others one to three days during the assessment period. Review of the EMR 2024 Progress Notes revealed the first incident involving R154, occurred on 1/18/2024 in when R154 grabbed R200 by the back of the neck and pushed her. Review of the undated admission Record in the EMR under the Profile tab revealed R200 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. R200 was discharged on 2/9/2024. R200's closed record was reviewed. Review of R200's Care Plan dated 12/31/2021 revealed R200 was confused and required redirection. In addition, R200 was documented with behavior problems including spending most of her day wandering throughout the unit and into other residents' rooms. R200 had an ADL self-care deficit and required assistance with some ADLs. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Five Day Investigation, dated 1/24/2024 and provided by the facility, revealed R200 had diagnoses including Alzheimer's disease, dementia, major depressive disorder, and anxiety disorder. R200 was impaired in short- and long-term memory, and decision-making. R200 wandered on the secure unit without the use of assistive devices. The investigation revealed, On 1/18/2025 [name] charge nurse [Licensed Practical Nurse (LPN)16], who oversees the care of [R200] states that she observed [R154] get up from his wheelchair and grab [R200] by the shoulder at the base of her neck and push her. She did not fall. The residents were separated, and [R200] was moved to safety with no apparent injuries. The Responsible Party for both [R154] and [R200] were notified of incident. The MD [physician's name] was notified . A 1013 [psychiatric hold detaining someone experiencing a mental health crisis for an involuntary psych evaluation and treatment within 48 hours] was received from the MD and [R154] was sent to [hospital name] ER [emergency room] for a psych evaluation. The family [sic] were notified. Social Service Director spoke to [name] [ER charge nurse] due to resident's behavior. Law enforcement was notified for transportation. NP, MD, Psych NP, and Ombudsman were also notified of the incident. Both resident's care plans were updated. Upon [R154's] return to the facility, a 30-day discharge notice will be immediately presented due to concerns of safety for himself and the other residents . Review of the staff Witness Statement dated 1/18/2024 from LPN16 revealed, Resident [R154] observed grabbing another resident [R200] by the neck and shoving her, resident [R200] did not fall. LPN16 was not employed at the facility at the time of the survey and was not available for interview. Review of the behavior Care Plan dated 3/1/2023 in the EMR under the Care Plan tab revealed, Per behavior monitoring and nurse notes, resident struggles with yelling, wandering, rejection of care, verbal aggression, and physical aggression. The goal was, [R154] will have less refusal during the next review period. The behavior Care Plan was updated on 1/23/2024 with, On 1/18/2024 Resident grabbed fellow female wandering resident by her shoulders pushing her out of his room. [On] 12/30/2024 Aggressive outburst towards female staff grabbing her neck. The goal was, Resident will not injure self or others when agitated thru [sic] review date. Interventions included, [R154] was sent to [name] hospital for a psych eval. MD, Psych NP, and NP was notified dated 1/23/2024 . b. The second incident involving R154 occurred on 12/26/2024, when R154 pushed R66 down to the floor and R66 sustained a sprained ankle as follows: Review of the undated admission Record in the EMR under the Profile tab revealed R66 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. Review of the annual MDS with an ARD of 2/18/2025 in the EMR under the MDS tab revealed R66 was rarely or never understood. The BIMS test was not conducted. R66 exhibited wandering behavior for four to six days during the assessment period. R66 was dependent on most ADLs. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Five Day Investigation dated 1/2/2025 revealed that on 12/26/2024, [R66] is a . female . Her diagnosis includes Alzheimer's disease and dementia with short- and long-term memory impairment. [R66] ambulates on the unit and often wanders into other residents' rooms. Her BIMS is 99. [R154] is a . male . His diagnosis includes neurocognitive disorder with Lewy bodies, dementia . severe with other behavioral disturbance . His BIMS is a 4. Investigation: [R66] wanders aimlessly with an unsteady gait about the unit. She is not aware of other's personal space or their personal items. At 1520 [3:20 PM] during shift change, .NA [nurse aide] observed [R154] sitting in his wheelchair outside his room when [R66] approached him. She [NA] was unable to intervene due to the distance between her and the two residents. She witnessed [R154] grab [R66] by her right arm, turn her around and push her in an attempt to redirect her . When she [R66] was attempting to ambulate, it was noted that she was unable to bear weight on her right leg and was placed into a wheelchair . NP [nurse practitioner] was notified and gave orders for [R66] to be transferred to the hospital for x-rays. RP [responsible party] notified . 911 was called . The Resident was transferred via stretcher to [name] hospital at 1614 [4:14 PM]. The . Police Department was notified with officer [name] responding to the facility . [R66] returned from the hospital at 2225 [10:25 PM] via stretcher. She was noted to have an immobilizer to her right ankle with a diagnosis of sprained ankle . She received a new order for cephalexin [antibiotic] . and trazadone [antidepressant] . A trauma assessment was completed for both residents. Both are followed by psychiatric services. Both of their care plans were updated. Actions put in place: The staff on Heritage Hall have been educated on close monitoring of the resident and to engage [R66] in activities during periods where she wanders into the space of others [R154] received a new order for Divalproex Sodium [anticonvulsant medication] . for impulse control. Review of a staff Witness Statement by Certified Nurse Aide (CNA)5 dated 12/26/2024 revealed, Yes I see [sic] [R154] turned around and push [R66] down to the floor. Other witness statements corroborated this statement. CNA5 was not available for interview during the survey. Review of R154's Behavior Care Plan dated 3/1/2023 in the EMR under the Care Plan tab revealed new interventions of 12/26/2024 - Consult psychiatric to eval and treat. 12/26/2024 - medication review and adjustment. 12/26/2024 - Staff to redirect resident behavior when observed aggression towards peers. c. The third incident involving R154 occurred on 4/1/2025, when R154 dragged R73 by her arm/sweater out of his room and pinned her down on the floor in the hallway and would not let her go until staff came and intervened. Review of the undated, admission Record in the EMR under the Profile tab revealed R73 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder and aphasia (language disorder affecting the ability to communicate). Review of the admission MDS with an ARD of 2/24/2025 in the EMR under the MDS tab revealed R73 was rarely/never understood, was severely impaired in decision making, and was impaired in memory. The BIMS test was not attempted. R73 exhibited wandering behavior one to three days during the assessment period. R73 was 5'2 tall and weighed 145 pounds. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Five Day Investigation dated 4/8/2025 and provided by the facility revealed, [R73] was observed by staff being dragged by a male resident out of his room with him holding onto her arm/sweater. Both parties were separated to different locations. Upon skin assessment, half of dollar discoloration noted to [R73's] left upper arm, and some redness was noted on her back with no open area. Range of motion was done with no limitation to all extremities and no pain or discomfort. The resident was assisted into her wheelchair with assist x2. Neuro check initiated per facility protocol with no changes in mental status. Administration, [psychiatrist], and RP notified . A trauma assessment was completed for [R73] There were no negative findings . Both of their care plans were updated. Actions put in place: Staff remained with [R154] until he left. [R154] was 1013'd and left facility on 4/1/2025 accompanied by officers x4 to [name] hospital with paperwork and bed hold policy. Upon departure, the resident was alert and oriented x3 with some forgetfulness. No bruise or open areas noted. He has not returned. Review of the Witness Statement dated 4/1/2025 for CNA4 provided by the facility read, I was standing at the nurses station I heard commotion down the hall. I saw resident [R154] dragging [R73] out the room and he had her pinned on the floor by her arms and shirt and did not let her go until me [sic] and other staff approached him and then he got verbally abusive after that. During an interview on 6/25/2025 at 8:37 AM, the Psychiatrist stated R154 was agitated and aggressive and had continued behavior during his stay. The Psychiatrist stated R154 was a veteran and exhibited symptoms of post-traumatic stress disorder (PTSD), stating R154 had been violent at home prior to admission. The Psychiatrist stated R154 got agitated when residents came into his room unannounced. The Psychiatrist stated R154 came in on Seroquel (antipsychotic medication) but had no history of mental illness warranting the medication, so it was discontinued, and Depakote was initiated for impulse control. The Psychiatrist stated non-pharmacological interventions were initiated including videos of his family and military service that were played on this TV. The Psychiatrist stated R154 abused residents, was an imminent threat and that was why he was sent on the 1013 holds. During an interview on 6/25/2025 at 9:12 AM, Certified Medication Aide (CMA), who also worked as a CNA, stated R154 did not want anyone in his room. CMA stated R154 yelled and screamed and was both verbally and physically aggressive with staff. CMA stated the main intervention was to redirect other residents if they were going towards his room which worked some of the time. CMA stated she witnessed the incident between R154 and R200. CMA stated R154 grabbed R200 by the back of her neck and pushed her out of his room. CMA stated R200 screamed and cried when the incident occurred. CMA stated R200 was significantly cognitively impaired and did not know she should avoid R154. CMA stated she did not remember R154 having increased supervision or being put on one-to-one supervision after this incident or the other ones. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/2025 at 12:11 PM, LPN6 stated she worked in the Heritage unit during R154's entire stay in the facility. LPN6 stated R154 was originally admitted to the Heritage unit and was later transferred to [NAME] hall but started exit seeking and he was brought back to Heritage unit. LPN6 stated R154 was capable of doing ADLs with supervision and he could walk. LPN6 stated R154 was alert and could express his needs; however, expressed some confusion about events and needs. LPN6 described R154 as being irritable and confrontational and he did not like wanderers. LPN6 stated if residents tried to wander in his room, R154 would try to get them out by whatever force. LPN6 stated there were quite a few residents on the Heritage unit that wandered. LPN6 stated these residents were redirected out of R154's space and offered diversional activities. LPN6 stated she was working when the incident on 12/26/2024 with R66 occurred. LPN6 stated when she came to the scene, R66 was lying on the floor and R154 was in the area. LPN6 stated R66 was startled and was later diagnosed with an ankle sprain after having difficulty walking. LPN6 stated staff were cautious around R154 and stated R154 had the potential to be a threat to residents. LPN6 stated R154's room was at the very end of the hallway. During an interview on 6/25/2025 at 1:08 PM, the Social Service Director (SSD) and Social Service Assistant (SSA) who were interviewed together stated R154 could be verbally and physically aggressive and spent most of his time in his room or in his doorway. The SSD stated R154 did not like people in his space and most of the incidents with other residents were a result of other residents coming into his room. The SSD stated her role in investigations of abuse was to complete trauma assessments after the incident and to check on the residents. The SSD stated all three of the residents (R66, R200, and R73) were severely cognitively impaired and would not remember the incidents after they occurred, indicating they were negative on the trauma screens. During an interview on 6/25/2025 at 3:01 PM, CNA4 stated R154 did not want other residents in his room and cursed at them if they tried to come in or tell them to get out. CNA4 stated it was normal to have wandering residents on the Heritage unit. CNA4 stated she witnessed the final incident on 4/1/2025 between R154 and R73. CNA4 stated she observed R154 in a standing position dragging R73 out of his room and then holding her down on the floor in the hallway. CNA4 stated R154 sat down in the hallway with his leg pinning R73 down on the floor. CNA4 stated several staff ran down there to make R154 let go of R73 and R154 cursed at the staff and let go of R73. CNA4 stated R73 does not talk but she was crying and upset when the incident occurred. CNA4 stated staff took R73 to her room and staff stayed with R154 until he was taken by the police to the hospital. CNA4 stated staff were to redirect R154 or walk away when became aggressive towards them and were to redirect residents who wandered near or into R154's room. CNA4 stated she was physically assaulted by R154 once when she was in R154's room and tried to leave the room. CNA4 stated R154 stood up from his wheelchair, blocked her from leaving his room and grabbed her neck, popping her necklace. CNA4 stated she yelled for help and was able to pry R154's hands from her neck when two other staff entered the room to assist. CNA4 stated R154 was strong, had been in the military, and stated he tried to choke her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115463	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbury Center of McDonough for Nursing & Healing	198 Hampton Street McDonough, GA 30253

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/2025 at 4:16 PM, the Administrator verified she was the abuse coordinator. The Administrator stated she had spoken with the Medical Director about discharging R154 and the 30-day notice for discharge was issued on 1/29/2024. The Administrator stated R154 had incidents of aggressive behaviors and posed a safety concern. The Administrator stated the normal process was for the unit manager and the SSD to talk with the family and see what area specific facilities a referral would be sent to. The Administrator stated she would not have handled referrals and placement. There should have been documentation about efforts to find placement after 30-day notice was issued. The Administrator stated R154's behavior had improved after the 30-day notice was issued. The Administrator stated the final incident on 4/1/2025 resulted in the daughter of R73 being afraid for R73 to remain in the facility on the unit with R154. A decision was made to issue the immediate discharge notice on 4/1/2025 due to the fear that R154 was going to hurt someone. The discharge notice was issued on 4/2/2025 after speaking with the Medical Director. During an interview on 6/25/2025 at 6:24 PM, Family Member (F)1 stated he and one other family member were next of kin for R154. F1 stated he was aware of R154's aggressive incidents towards other residents and did not condone this behavior. F1 stated that residents roamed freely on the Heritage unit and family had observed many instances of other residents entering or trying to enter R154's room. F1 stated R154 kept his door shut to keep people from coming into his room. F1 stated, From our perspective they do not have control of roaming patients. This does not seem right. 2.Review of the Census tab in the EMR revealed R60 was admitted on [DATE]. Review of the Med Diag tab in the EMR revealed R60 had diagnoses including paraplegia and complete lesion of the C5, C6, and C7 level of cervical spinal cord Review of the Care Plan under the Care Plan tab in the EMR revealed R60 had a focus with interventions related to C5-C7 lesion of the spinal cord initiated on 2/24/2022. A focus with interventions related to restorative nursing for passive range of motion as tolerated was initiated on 1/24/2025. A focus with interventions related to paraplegia with complaints of pain/spasm to bilateral extremities initiated on 2/24/2022. Review of a quarterly MDS with an ARD of 12/1/2024 under the MDS tab in the EMR revealed R60 had a BIMS score of 15 out of 15 indicating no cognitive decline. R60 was impaired on both arms and both legs. In an interview on 6/24/2025 at 5:10 PM, R60 stated he remembered R160 well. R60 stated R160 was a good roommate for the longest time and then changed one day. He stated they were talking about stuff one day and then R160 said to him, Shut up or I will kick your ass. R60 stated he immediately became and remained silent because he was a little freaked out by the statement. R60 stated R160 came over and punched him on his ear, cheek, and across his nose. Observation of R60 indicated he was unable to move his arms. Review of a communication note dated 1/3/2025 under the Prog Note tab in the EMR revealed, resident alert and verbal . Being monitored for altercation with roommate. He was hit in the face by his roommate. No active bleeding noted at this time, no swelling, or c/o voiced. Call light in reach. (continued on next page)

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	115463	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbury Center of McDonough for Nursing & Healing	198 Hampton Street McDonough, GA 30253

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a communication note dated 1/3/2025 under the Prog Note tab in the EMR revealed, spoke with resident RP .[granddaughter] via phone whom [sic] called back concerning 1/2/2025 physical incident with resident and resident roommate. Resident RP made aware of full details of incident and well as resident current status. Plan of care ongoing safety maintained. Review of a communication note dated 1/7/2025 under the Prog Note tab in the EMR revealed, attempt made to call resident RP .[granddaughter] via phone. No answer. Voicemail full. Call was concerning resident request to press charges on former roommate for incident on January 2nd, 2025. The local police dept. contacted and resident made aware an officer will be in to receive his statement. will attempt to contact RP again. Review of a nurse note dated 1/2/2025 under the Prog Note tab in the EMR revealed, it was reported that resident [R160] verbally assaulted his roommate [R60], resident was immediately removed from room, Resident denied incident and took no accountability for alleged incident. Nursing supervisor made aware. 911 was contacted, resident RP contacted, and Tele med notified. Resident removed from room with belonging to room [room number] until further investigation. Plan of care on going, and safety maintained. A nurse note dated 1/2/2025 revealed, Resident [R160] left his room, sat next to the ice cooler in the hallway for a long time before we found out that he assaulted the roommate [R60], when asked what happened he denied ever touching the roommate, when asked to move out of the room, he refused, the police was called in, we all wrote down our statements and gave them, Meanwhile he [R160] has been transferred to room [room number]. His sister came to the facility to talk with him. Review of the facility self-report to the State Agency revealed that on 1/2/2025 the charge nurse was passing meds when staff asked her to look at R160's roommate. The nurse noted scratches on the roommate's face and the tip of his nose. The roommate stated R160 had hit him. The two residents were kept separated as R160 was sitting in the hall when the nurse assessed the roommate. The police were called to the scene. R160 denied striking his roommate but did admit to them arguing about some food that was brought in for R160. A trauma assessment was completed for the roommate, R160 was referred to psychiatric services, staff were re-educated on Managing Aggression and Behaviors which included de-escalation techniques, and both care plans were updated. Other residents were interviewed during the investigation. All timeframes for reporting were per requirement. The facility could confirm a verbal altercation but did not substantiate physical abuse. In an interview on 6/26/2025 at 12:00 PM Unit Manager (UM) stated she remembered the incident between R60 and R160. She stated she was informed there was an altercation, so she went to investigate. When she arrived at the room, R160 was sitting outside the door and the privacy curtain was pulled between the beds in the room. UM stated R160 would not look up at her when she asked what was going on. When she questioned R60, he stated R160 had hit him and that his face hurt. UM assessed scratches to his face and nose. UM cleaned R60's wounds and administered his pain medication. UM stated she then took R160 to another room to keep them separated and made the calls to the representatives, physician, and 911. UM stated she believed by what she saw and heard that R160 meant to hit R60 and the interaction was abuse. In an interview on 6/25/2025 at 1:45 PM the Administrator confirmed that R60 had requested a police officer so he could press charges against R160.