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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115563	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbury Center of Jackson for Nursing and Healing	922 McDonough Road Jackson, GA 30233

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46565 Based on staff interviews, record review, and a review of the facility policy titled Notification of Changes, the facility failed to notify the resident's representative of a change in the resident's condition for 1 of 3 sampled residents (R) (R5) reviewed for notification of change in condition. Findings included: A facility policy titled, Notification of Changes, revised date of 1/2024, revealed Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/26/2023, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Review of the care plan for R5, initiated on 12/21/2023, revealed the resident was new to the facility. Interventions directed the staff to notify the resident's family of changes in the resident's condition. A review of Progress Notes for R5 dated 12/31/2023 at 1:53 pm revealed the resident once again refused to take their scheduled morning medications. A review of the Progress Notes, for R5 dated 1/1/2024 at 6:18 pm, revealed the resident refused their morning medications, therapy, meals and activity of daily living care. Per the progress note, the resident stated they wanted to go home and needed to speak with a family member. The Progress Note indicated the staff called the resident's family member at their request. Per the Progress Note, later the resident refused to take a shower and complained that they had stomach pains. A review of the Progress Notes, for R5 dated 1/2/2024 at 5:53 pm, revealed the resident was sent to the emergency room for treatment and evaluation of acute abdominal pain. A review of the medical record for R5 revealed no evidence the resident's family, or their responsible party were notified the resident refused medication, meals, therapy, Activities of Daily Living (ADL) care, or the resident's complaint of stomach pain. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/2024 at 10:03 am, R5's family member (FM) #1 stated when they arrived at the facility to visit the resident on 1/2/2024, they found the resident in bed with a dry appearance and a swollen stomach and abdomen. FM 1 stated they went to the nurses' station and were told the resident had refused their medications several times and had not asked for any help, which is why no family had been notified. During an interview on 7/8/2024 at 5:47 pm, R5's FM 2 stated they were never notified of the resident's condition. During an interview on 7/8/2024 at 6:16 pm, R5's FM 3 stated they were notified the resident refused their medication, meals, or ADL care. During an interview on 7/11/2024 at 1:50 pm, the Director of Nursing (DON) stated FM 2 was listed as R5's responsible party. The DON stated she expected the staff to notify the resident's RP of any change in the resident's treatment or condition and documentation of such notification should be in the resident's progress notes.

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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** 46565 Based on staff interviews, record review, and a review of the facility policy titled Abuse, Neglect and Exploitation, the facility failed to protect the resident's right to be free from verbal and physical abuse by staff. The Certified Nursing Assistant (CNA) forcefully pushed the resident (R) (R1) down, grabbed the wheelchair, and prevented the resident from leaving the room. Psychosocial harm occurred on 7/13/2023 when a CNA voiced racial comments causing R1 to become distraught, scared, and crying. Due to the verbal abuse, R1 left the facility and did not return. Findings include: A facility policy titled, Abuse, Neglect and Exploitation, revised 1/2024, revealed policy: 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. The policy specified, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age ability to comprehend, or disability. The policy revealed, Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Per the policy, Involuntary Seclusion refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative. A review of the Admission Record revealed that R1 had a diagnosis of legal blindness, major depressive disorder, and anxiety disorder. An annual Minimum Data Set (MDS) dated [DATE] for R1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. A review of the care plan for R1, dated 2/2/2023, revealed that R1 had an alteration in vision function, as the resident was blind. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's final investigation, dated 7/19/2023, revealed that R1 reported that a CNA made comments to them that were of a sexual and racial nature. The investigation indicated the resident had no physical harm but was distraught after the incident. The investigation revealed the resident contacted their responsible party (RP) on the evening of 7/13/2023 and reported that a CNA made inappropriate comments to R1 and asked questions that upset R1. Per the investigation, the resident's RP contacted a registered nurse (RN) supervisor and informed the RN supervisor that they were on their way to the facility to get the resident. The investigation revealed the RN supervisor immediately visited the resident, offered support, and gathered information about the incident. Per the investigation, R1 left the facility with their RP and did not return, the CNA was interviewed and escorted out of the facility, and the police were called. According to the investigation, the camera footage was reviewed and all staff and residents that were observed in the area at the time of the incident were interviewed, and statements were obtained. The investigation revealed that R1 reported that the incident occurred in the shower room; however, the camera footage indicated the incident took place in the small dining room across from the shower room. The investigation indicated the resident was legally blind and did not realize where they were in the facility. Per the investigation, two CNAs were observed in the room with R1 while the resident waited to enter the shower room. One CNA was observed to talk to the resident, but the content of the conversation was unknown as there was no audio available. The other CNA was present and noted to sit at a table and laugh and make occasional comments. Per the investigation, when R1 became agitated, as evidenced by their attempts to leave the small dining room, R1 was blocked by the CNA. The investigation indicated that R1 was eventually taken back to their room, and it was reported that the resident refused their shower. The investigation revealed one staff member and one resident witnessed the incident and confirmed R1's recollection of the events. Per the investigation, the allegation of abuse was substantiated, and the facility would continue to cooperate with the police department's investigation, and both CNAs (CNA #5 and CNA #6) were terminated. Contained with the facility's investigation file was a handwritten statement from R1's RP dated 7/14/2023, which revealed that R1 tried to get up and was forcefully pushed the resident down. The statement indicated there were two, one laughed, and the other was forceful. Per the statement, a lady stated the resident had dementia. Contained with the facility's investigation file was a handwritten statement from the RN Supervisor dated 7/13/2023, which revealed at 9:30 pm, the RN Supervisor received a telephone call from R1's RP, who stated the resident stated a CNA had said hurtful things to the resident and the RP was on their way to pick up R1. The statement revealed the RN Supervisor went to the resident's room and the resident reported that a CNA came to take to them to the shower, but while the resident waited for a shower, the CNA insisted the resident give her a hug. The statement indicated that when the resident refused, the CNA accused the resident of not liking African American people. The statement revealed the resident stated the CNA then stated the resident's spouse was a member of a white supremacist group, asked if the resident ever dated an African American person, and was the African American person better in bed than their spouse. Per the statement, the resident lied to the CNA and stated they had dated an African American person just so the CNA would leave them alone. The handwritten statement revealed the resident stated they were scared and yelled for another staff person, but that staff person did not come. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Contained within the facility's investigation file was a statement from R10 dated 7/13/2023, which revealed while the resident waited for their turn for a shower, they overhead CNA 5 and an unknown resident's conversation. R10 stated they heard CNA 5 ask the resident if they did not want to receive a shower because a [African American] lady was giving it. R10 stated the CNA continued to ask the resident if their spouse was a member of a white supremacist group. R10 stated the resident seemed scared and it sounded like the resident was crying. R10 stated the CNA was very aggressive and intimidating, and they were too afraid to intervene. A quarterly MDS, dated [DATE], revealed R10 had a BIMS score of 14, which indicated the resident had intact cognition. A review of the initial police report dated 7/14/2023 revealed an investigation in reference to a possible assault, with interviews obtained on this date. On 7/19/2023 the staff reviewed all videos provided and stated no criminal violations. On 8/11/2023, the staff spoke with the family and R1 regarding the incident and followed up with another review of video footage on 8/16/2023. The report detailed on 8/18/2023 no probable cause to believe that a crime has occurred. The video footage was requested and sent to the sheriff's office on 8/16/2023 A review of the initial sheriff's report dated 9/8/2023 revealed the following from an audio and video review of facility camera footage. R1 stated she was scared to death of what the woman was going to do so she was trying to get away. She didn't want to take a shower anymore because she was afraid of being left in the shower. R1 stated she was in so much fear the woman would take a gun out and shoot her. R1 revealed she never took her clothes off, and the lady grabbed her by the arm and hurt it. She described the grab as hard. R1 stated she was forced to stay in the room, and she cried, bawled, and begged them to let her go. R1 further revealed she told them she dated a black man for two years. She thought it would make them stop talking about it. The staff asked about the penis size of a black man compared to a white man. The staff member asked R1 if her family was a member of the KKK, and due to her visual impairment, she could not navigate in the room with the wheelchair and began running into walls. R1 stated they asked if black kids were allowed to go to class with her, eat lunch, and eat the same food. R1 said she was afraid and tried to get out of the chair and the staff member threw her back in the chair. The report reveals a visual on video of the staff member pushing R1 down the hall, proceeding in a circle, and then continuing down the hall, appearing to be an intentionally misleading act. The conclusion of the investigation details probable cause has been established for the offense of Cruelty to the Elderly, and taking certain factors surrounding the case into consideration, charges have been held off at this time. Video footage was made available on 7/25/2024. However, the video was unable to be downloaded or viewed. On 7/9/2024 at 11:30 am, the surveyor attempted to interview CNA 5; however, the telephone number provided was not a working number. On 7/9/2024 at 11:33 am, the surveyor attempted to interview CNA 6; however, the telephone number provided was not a working number. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/9/2024 at 11:00 am, the Administrator stated R1 was blind. The Administrator explained that the CNA took the resident for a shower, but the shower room was full, so they went across the hall to the break room to wait in line. The Administrator further revealed that R1 wanted to leave but could not find their way out, and the CNA blocked the resident from leaving. The Administrator stated there was another staff person in the room who was eating dinner and witnessed the incident but did not intervene. The Administrator stated the police were called, and the two staff (CNA 5 and CNA 6) were terminated. During a follow-up interview on 7/10/2024 at 9:51 am, the Administrator stated from the review of the camera footage, one could tell that R1's demeanor changed when they tried to get out the door, but the CNA grabbed the back of the resident's wheelchair which caused the resident to circle the room. The Administrator revealed both CNAs (CNA 5 and CNA 6) laughed while the resident searched for the door, and one CNA was noted to touch the resident. During an interview on 7/11/2024 at 1:00 pm, Nurse Practitioner (NP) 2 stated she remembered R1 and the resident was blind, picked at their skin, and had no history of making false accusations of abuse.