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	01/24/2026

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

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, and a review of the facility's policy titled Resident and Family Grievances, the facility failed to ensure that a resident's verbal complaint was treated as a grievance, documented, and investigated in accordance with federal requirements. Specifically, when one Resident (R6) reported to the Social Service Director (SSD) that a staff member (Environmental Services Housekeeper (EVS) EE) entered her room on two occasions, making her feel uncomfortable. The sample size was 8.Findings include:Review of the facility policy titled Resident and Family Grievances revision date September 2025, revealed Policy: It is policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines: 1. The Director of Social Services and the Administrator have been designated as the Grievance Officials for this center. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary considering specific allegations. 8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. 10. Procedure: b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right. e.The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances.Review of the admission Record for R6 revealed she was admitted to the facility on [DATE] and a diagnosis of anxiety but not limited to anxiety.Review of the resident's most recent Prospective Payment System (PPS) Part A MDS dated 12/312025 revealed that a BIMS was assessed as 15, which indicated cognitively intact. Section D not assessed. Section E not assessed.An interview on 1/16/2026 at 10:39 am with R6 stated that on two occasions, the EVS Housekeeper EE entered her room early in the morning while she was dressing. R6 revealed that she does not recall if the EVS Housekeeper EE staff knocked. She stated she found it odd that he entered her room at those times. R6 stated that it made her feel uncomfortable. The resident stated she reported the incident to the Social Worker.An interview on 1/20/2026 at 10:11 am with the Social Service Director (SSD) stated that on 1/7/2026, around 9:30 am, she went to R6's room and spoke with the resident. She stated that R6 told her it was odd that EVS Housekeeper EE had been in her room twice. The SSD stated she asked the resident whether the EVS Housekeeper EE had touched her, and the resident responded no. The SSD stated she did not file it as a grievance, and no further investigation was conducted at the time of the resident's interview.

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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, staff and resident interviews, record review, and a review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to protect the Resident's (R) (R1) right to be free from sexual assault by Environmental Service (EVS) Housekeeper EE. The sample size was eight.On January 20, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), Regional Director of Clinical Operations, and Regional Director of Operations (RDOP) were informed of the Immediate Jeopardy (IJ) on January 20, 2026, at 5:10 pm. The noncompliance related to the IJ was identified to have existed on January 6, 2026.An Acceptable IJ removal Plan was received on January 23, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 8, 2026.Findings include:Review of the policy titled Abuse, Neglect and Exploitation, with a reviewed/revised date of 12/2025, 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. Definitions: Sexual abuse is non-consensual sexual contact of any type with a resident.Review of the admission Record for R1 revealed she was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, anxiety, major depressive disorder, and vascular dementia.Review of the resident's most recent comprehensive Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was assessed as 12, which indicated moderately cognitive impairment. Section D: none. Section E: No behavior exhibited. Cognitive Loss/Dementia triggered as an area of concern on the Care Area Assessment Summary (CAAS).Review of the resident's most recent quarterly MDS dated [DATE] revealed a BIMS was assessed as ten, which indicated moderately cognitive impairment. Section D: revealed a mood of feeling down, depressed, hopeless. Section E: no behavior exhibited.Review of the care plan revised on 1/13/2026 revealed that R1 had poor decision-making skills, required cueing and reminders for daily tasks. Interventions to be implemented included staff to monitor and give redirections as needed.Review of the Facility Incident Report Form dated 1/6/2026 revealed: a staff walked into R1's room and observed staff member with his pants down and it appears that the resident was engaged in oral sex with female resident {sic}.Review of the facility camera footage located in the human resource office with the Regional Director of Maintenance and the Human Resource Director (HRD). The camera footage was dated 1/6/2026 and started at 7:00 am military time. At 7:37 am, R1 came out of her room, turned to the right, exited the frame, and went outside the field of view (FOV). R1 reentered the FOV at 7:38 am and returned to her room, closing the door behind her. There was no other observation of R1 leaving the room. At 3:23 pm, a male staff member identified as EVS Housekeeper EE entered the FOV from the back door at the end of __ Hall, walked down the hall, and entered an additional resident's room __ (did not knock). At 3:24 pm, the EVS Housekeeper EE reentered the FOV coming out of room __, walking down the hall, and remained in the FOV. At 3:24:13 pm, the EVS Housekeeper EE knocked on R1's door and closed the door behind him. At 3:36:38 pm, a female staff member identified as Certified Nursing Assistant (CNA) DD entered the FOV, opened the door to R1's room, and walked in. The female CNA DD exited the room at 3:36:57 pm, turned right, exiting the frame. At 3:37:11 pm, the EVS Housekeeper EE reentered the frame, standing at the door of R1's room. The EVS Housekeeper EE looked in both (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	directions and walked out of the room to the end of __ Hall. It took the EVS Housekeeper 22 seconds to enter the code and exit the back door of __ Hall. At 3:43:55 pm, two staff members, identified as two nurses, reentered the FOV and entered R1's room and exited the room at 3:44:15 pm.A review of the local police department body camera footage dated 1/6/2026, interview at time stamp 3:22 -5:18 with R1. During the interview, the resident verbalized, My mind is gone. The resident also verbalized to the Administrator and a police officer, I am not saying I enjoyed it. He enjoyed it. R1 additionally verbalized, It ain't about me, it is about him.An interview on 1/13/2026 at 12:23 pm with the Director of Nursing (DON) was conducted; the Administrator was present. The DON stated that on 1/6/2026, she received a call from the Assistant Director of Nursing (ADON) and was informed that CNA DD was passing ice water, and when entering R1's room, she observed the EVS Housekeeper EE with his penis in R1's mouth. The DON asked the ADON whether R1 was okay and whether the resident had been assessed. The ADON informed her that R1 had been assessed and was in no pain or distress. ADON informed her that the EVS Housekeeper EE had left the facility, and the police had been called. She informed the ADON to have someone stay with the resident at all times. The DON stated she called the Administrator, the Regional Director of Clinical Operations, the Regional Director of Operations, and the Medical Director. The DON revealed that the Medical Director instructed her to ensure someone was with the resident and to call him back once she had assessed the resident. The Medical Director also instructed her to send R1 out to the hospital for evaluation. The DON stated she arrived at the facility at 4:41 pm and went directly to the resident's room. The DON stated she assessed R1. She offered to send the resident to the hospital, and R1 refused. She revealed that she called the Medical Director, who ordered a complete head-to-toe skin check, and to ensure her psychosocial needs were met by consulting with psychiatric services, and to encourage the resident to engage in activities outside of the room, and placed R1 on every 15-minute checks. She stated R1's family was notified.A phone interview on 1/19/2026 at 4:10 pm with CNA DD stated that on 1/6/2026, she was pulled from her unit to __ Hall. CNA DD stated was passing ice water and entered R1's room. She stated the EVS Housekeeper EE was standing with his pants down, and R1 was lying in the bed. She stated the EVS Housekeeper EE penis was in the resident's mouth. CNA EE revealed that she gasp and the EVS Housekeeper EE looked at her and said, Oh shit, and ran into the bathroom. She stated that the EVS Housekeeper EE had a scary look in his eyes. She stated she left the room to get the nurse. CNA DD revealed she was in the room when the cameras were reviewed, and that man (EVS Housekeeper EE) was in the room for fifteen minutes with a resident who has dementia.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of the Administrator's Job Description, and review of the facility policy titled, Abuse, Neglect and Exploitation, the Administration failed to provide protective oversight of the facility resident's to prevent the sexual assault against Resident (R) (R1) by the male Environmental Service (EVS) Housekeeper EE and failed to identify the EVS entering and remaining in resident rooms (R6) at unusual times, with no cleaning supplies, or housekeeping carts making them feel uncomfortable and afraid. Specifically, the facility Administrator failed to conduct an unbiased investigation and utilized leading questions towards the resident, implying the resident consented to sexual contact with the EVS Housekeeper EE. This failure compromised the integrity of the abuse investigation and minimized the seriousness of staff - to - resident sexual abuse. The sample size was eight.On January 20, 2026, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator, Director of Nursing (DON), Regional Director of Clinical Operations, and Regional Director of Operations (RDOP) were informed of the Immediate Jeopardy (IJ) on January 20, 2026, at 5:10 pm. The noncompliance related to the IJ was identified to have existed on January 6, 2026.An Acceptable IJ removal Plan was received on January 23, 2026. Based on observation, record reviews, and review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on January 8, 2026.Findings include:Review of the undated document titled, Administrator-Job Description revealed position purpose is leads, guides, and directs the operations of the healthcare facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents. Plans, develops, organizes, implements, evaluates, and directs the facility's programs and activities in accordance with state and federal laws and regulations. Performs rounds to observe residents and ensure overall needs are being met. Knows residents by name and sight. Practices management by walking around. Makes himself/herself available to employees at all levels by practicing an open-door policy. Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etc. are reported to the correct entity within the stated regulatory requirement. Protects residents from abuse and cooperates with all investigations. Promotes and encourages an environment of trust among all employees related to the overarching goal of resident safety and abuse prevention.Review of the policy titled, Abuse, Neglect and Exploitation with a reviewed/revised date of 12/2025, III. Prevention of Abuse, Neglect, and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.Review of the police body-worn camera video/audio dated 1/6/2026 revealed an interview with the Administrator and R1, with the police officer present. During the interview, the Administrator stated, You know I had to make sure you're alright, and nobody just doing something in here; so, you told me it has been happening for a while, right? R1, Yeah. Administrator, You say y'all kind of talk. I asked her how it happened. (Speaking to the police officer), (Administrator speaking to R1) He just come in and y'all just talk then it goes to that. R1, [NAME]. (while shaking her head yes). Administrator, Is he forcing himself on you. R1 Mhm, (while shaking her head no). Administrator, This something you consent, and you like for that to happen? R1, It ain't no big deal, Administrator, Ok, R1 I am [AGE] years (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	old, I can put anything in my mouth that I want to. Administrator, And he does not, let me ask you this again, does he release himself in your mouth? R1 No. Administrator, And you said it has been happening for like months or has it been? R1 My mind is gone. Administrator, You don't know how long, but it has been several times? R1 Don't ask me how long it has been going on, I couldn't tell you. Administrator, You said has he, have yall had any kind of., R1 No. Administrator, None of that has happened, just him putting his penis in your mouth? R1 Yeah Administrator, And you enjoyed? R1 I didn't say I enjoyed it; he enjoyed it. It is not about me, it is about him. {sic}Review of the five- day follow-up submitted on 1/13/2026 conclusion staff to resident sexual contact was substantiated. Accordingly, while the resident's right to sexual expression is acknowledged and respected, __ Environmental Services (EVS) Housekeeper EE should have informed the facility's Administration of resident's desire for sexual encounter. The resident was assessed as alert and oriented and demonstrated the ability to express personal preferences and desires. The facility is engaged in protecting her dignity and confidentiality for her sexual desires.In an interview on 1/16/2026 at 10:39 am, R6 (BIMS 15) stated that on two occasions, the EVS/Housekeeper EE entered her room early in the morning while she was dressing. She stated she does not recall if the EVS/Housekeeper staff knocked. She stated she found it odd that he entered her room at those times. The resident stated it did make her feel uncomfortable. The resident stated she reported the incident to the Social Worker.An interview on 1/20/2026 at 10:11 am with the Social Service Director (SSD) stated that on 1/7/2026 around 9:30 am, she went to R6's room and spoke with the resident. She stated that R6 told her it was odd that EVS Housekeeper EE had been in her room twice. The SSD stated she asked the resident had the EVS Housekeeper EE touched her and the resident responded with no. The SSD stated that she did not file it as a grievance, and that no further investigation was conducted at the time of the resident's interview.In a phone interview on 1/19/2026 at 4:10 pm, Certified Nursing Assistant (CNA) DD stated on 1/6/2026 she was pulled from her unit to Hall. She stated she was passing ice water and entered R1's room. She stated the EVS Housekeeper EE was standing with his pants down, and R1 was lying in the bed. She stated the EVS Housekeeper's penis was in the resident's mouth. She stated she gasped, and the EVS Housekeeper looked at her and said, Oh shit, and ran into the bathroom. The CNA stated she was in the room when the cameras were reviewed and that man (EVS Housekeeper) was in the room for fifteen minutes with a resident who has dementia.In an interview on 1/20/2026 at 3:08 pm, the Regional Director of Operations stated R1 initiated the contact and that she had a BIMS score of 10-15. She further stated the incident was consensual. When asked if an employee was receiving fellatio from a resident, would that be a violation of the abuse policy? The RDOP stated, Yes.In a post-survey phone interview on 2/5/2026 at 4:20 pm, the Administrator revealed that she engaged in the line of questioning with the resident (R1) through her training and master's degree in social services. The Administrator stated that this was more of a style for questioning to gauge what was going on with the resident (R1), and it comes from professional training. She stated that the resident was alert, oriented, and communicated clearly during the interview.R1 and R6 both reside in the locked behavioral unit at the facility.