STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115469	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbury Center of Conyers for Nursing and Healing	1420 Milstead Road Conyers, GA 30012

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and record review, the facility failed to ensure one of 75 sampled residents (R) (R7) was provided with a call device suitable for the resident's use. This deficient practice had the potential to place R7 at risk of unmet needs and a diminished quality of life. Findings include:Review of R7's admission Record revealed she was admitted [DATE] with diagnoses that included, but were not limited to, unspecified injury at unspecified level of cervical, unspecified injury at unspecified level of cervical spinal cord, and schizophrenia, unspecified.Review of the Comprehensive Minimum Data Set (MDS) assessment for R7, dated 7/15/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of eight (indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented R7 had upper extremity impairment on both sides, was dependent on eating, oral hygiene, toileting, bathing, dressing, personal hygiene, mobility, and transfers. Review of the Care Plan for R7, dated 8/22/2025, revealed no documentation regarding R7's inability to use upper extremities or to use the call button to activate the emergency call light.Observation and interview on 8/25/2025 at 1:20 pm with R7 revealed she was lying in a slightly elevated bed, with a call light approximately six inches from her right hand. Further observation revealed her right hand was immobilized in an inflatable brace. When the call device was placed in her hand, she was unable to press the button to activate the emergency call light. R7 stated she had to wait for someone to check on her for assistance. Observations on 8/26/2025 at 8:48 am and 3:00 pm of R7 revealed that the call button was within reach; however, R7 was unable to activate the call button.Observation on 8/27/2025 of R7 revealed a flat call light device within R7's reach; however, R7 was unable to activate the flat call device. In an interview on 8/25/2025 at 1:22 pm, Certified Nursing Assistant (CNA) confirmed R7 was physically unable to activate the call button and stated the resident needed a push call light.In an interview on 8/26/2025 at 3:04 pm, Licensed Practical Nurse (LPN) ZZ confirmed she was aware R7 was unable to use the call button to call for help and stated the resident should have a call device she could use. LPN ZZ stated that a replacement call light for R7 had been discussed in the clinical management meeting about a week ago, and it was agreed upon by all that a replacement call light would be ordered. In an interview on 8/26/2025 at 3:12 pm, the Administrator confirmed that an assessment should have been completed on R7 on admission, and a call light that the resident could activate should have been provided to the resident. The Administrator further stated that if the facility did not have a call device that the resident could use, one would be ordered. In an interview on 8/26/2025 at 3:14 pm, the Director of Nursing (DON) stated the nurses were expected to assess and identify resident needs for call lights. In a concurrent observation and interview on 8/28/2025 at 10:05 am, at R7's bedside, the DON confirmed that R7 could not activate the push pad call light and stated that a breath-activated call device was needed and would be ordered. The DON stated a 24-hour log of staff checks on R7 would be instituted immediately, with every 15-minute checks (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during R7 nighttime tube feeding infusion, and every 30-minute staff checks during the day, until a suitable call device was obtained for R7 to use.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on resident representative and staff interviews, record review, and review of the facility's policy titled Bed Hold Prior to Transfer, the facility failed to ensure one of two residents (R) (R4) reviewed for hospitalization was provided with a written bed hold notice or reason for transfer at the time of transfer. This deficient practice had the potential to place R4 or the resident representatives at risk of being uninformed about their rights related to hospital transfer and subsequent return to the facility. The sample size was 75. Findings include:Review of the facility policy titled Bed Hold Prior to Transfer, reviewed/revised 3/2025, revealed the Policy section stated, It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. The Policy Explanation and Compliance Guidelines section included, 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies a. the duration of the State bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. the reserve bed payment policy in the state plan policy if any. c. The facility policies regarding bed hold periods to include allowing a resident to return to the next available bed. 3. The facility will keep a signed and dated copy of the bed hold notice information given to the resident and resident representative in the resident's file and or medical record. 4. The facility will provide this written information to all facility residents, regardless of their payment source.Review of the Discharge Minimum Data Set (MDS) assessment for R4, dated 6/21/2025, revealed Section A (Identification Information) documented the resident was discharged to a short-term general hospital on 6/12/2025, with return anticipated. Review of the Discharge Minimum Data Set (MDS) assessment for R4, dated 7/13/2025, revealed Section A (Identification Information) documented the resident was discharged to a short-term general hospital on 6/30/2025, with return anticipated.Review of the Quarterly MDS assessment for R4, dated 8/8/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BMS) score of 00 (indicating the resident was not cognitively intact to complete the assessment). Review of the Clinical Census for R4 revealed a hospital paid leave on 6/12/2025 and 6/30/2025.Review of the clinical record for R4 revealed no evidence of the provision of a notice of a bed hold or reason for transfer provided to R4 or the resident representative for the transfers dated 6/12/2025 and 6/30/2025.In an interview on 8/27/2025 at 3:23 pm, the resident representative for R4 stated that a written bed hold notice was not provided when R4 was transferred to the hospital on 6/5/2025 or 6/30/2025. He stated that this was the first time he had heard the term bed hold. In an interview on 8/27/2025 at 5:00 pm, Licensed Practical Nurse (LPN) PP stated that when a resident was transferred from the facility to a hospital, the nurse was responsible for calling the family or responsible party, calling the physician, and writing the orders being sent with the resident. She stated that she was not responsible for bed holds, and the business office or admissions was. In an interview on 8/28/2025 at 1:06 pm, the Business Office manager (BOM) revealed that all new admissions were asked at the initial 72-hour meeting if they wanted to pay for the bed hold if they were transferred to the hospital, or if they wanted to be discharged and readmitted upon return. She also stated that it was the nursing staff's responsibility to provide the residents or their representatives with a copy of the bed hold policy before they leave the facility. She stated that copies of the bed hold policy were located at the nurses' station. In an interview on 8/28/2025 at 1:15 pm, the Unit Manager (UM)/LPN XX revealed that part of the process when a resident was transferred to the hospital was to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide the residents with a bed hold policy. She stated that it is not documented anywhere, but it was just known to be provided. In an interview on 8/28/2025 at 2:40 pm, the Administrator revealed that the nurse was responsible for providing the residents with the bed hold policy upon transfer to the hospital, and the business office documented a bed hold in the billing. The Administrator was unable to locate proof that a written bed hold notice was provided to R4 or the resident representative for the hospital transfers dated 6/5/2025 and 6/30/2025. She stated that her expectation was for the nursing staff to provide the bed-hold policy to residents upon transfer to the hospital, and for it to be documented in the resident's record.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Medication Administration, the facility failed to ensure the medication error rate was less than 5 percent. The medication error rate was 7.69 percent, with two errors from 26 opportunities for two of four residents (R) (R89 and R77) observed for medication administration. This deficient practice had the potential to place R89 and R77 at risk of adverse effects or a lack of desired effects from the medications. Findings include:Review of the facility's policy titled Medication Administration, revised 4/2025, revealed the Policy section stated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The Policy Explanation and Compliance Guidelines section included, . 10. Ensure that the six rights of medication administration are followed: a. right resident, b. right drug, c. right dosage, d. right route, e. right time, f. right documentation. 17. Administer medications as ordered in accordance with manufacturer specifications. 1. Review of the electronic medical record (EMR) revealed R89 was admitted to the facility on [DATE] and diagnoses included, but were not limited to, hyperkalemia, acute kidney failure, and encephalopathy.Review of the Quarterly Minimum Data Set (MDS) assessment for R89, dated 6/5/2025, revealed Section K (Swallowing/Nutritional Status) revealed no swallowing disorder.Review of the Physician's Orders for R89 included an order dated 10/28/2023 for atorvastatin calcium oral tablet (a medication used to lower cholesterol) 40 milligrams (mg) daily. Further review revealed an order dated 12/5/2023 of May alter medication by crushing, opening capsules, and administering with food/liquid unless contraindicated.Observation of medication administration on 8/27/2025 at 8:12 am with Licensed Practical Nurse (LPN) PP revealed LPN prepared, crushed, and administered atorvastatin calcium oral tablet 40 mg to R89.In an interview on 8/27/2025 at 8:12 am, LPN PP confirmed she crushed the atorvastatin oral tablet and administered it to R89. She further confirmed the medication should not be crushed. In an interview on 8/27/2025 at 2:54 pm, the Registered Pharmacist (RPh) stated that atorvastatin calcium tablets should not be crushed.In an interview on 8/28/2025 at 9:10 am, the Director of Nursing (DON) confirmed that medications were to be crushed according to policy, and nurses should follow the list on each medication cart for reference. 2. Review of the EMR revealed R77 was admitted to the facility on [DATE] and diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral vascular accident, dysarthria, anarthria, and muscle weakness.Review of the Physician's Orders for R77 revealed an order dated 11/18/2022 for MiraLax powder 17 grams per scoop, one scoop per day for constipation.Observation of medication administration on 8/27/2025 at 8:48 am with LPN AA revealed LPN AA reviewed the physician's orders and prepared and administered the two scoops of polyethylene glycol [generic medication for MiraLax] to R77.In an interview on 8/27/2025 at 9:00 am, LPN AA confirmed R77 should have received one scoop of polyethylene glycol, and he administered two scoops of polyethylene glycol powder because the resident asked for a second scoop. The LPN confirmed he should have given R77 one polyethylene glycol scoop of powder as ordered. In an interview on 8/28/2025 at 9:00 am, the Director of Nursing (DON) stated that there was no exception for not following the doctor's order. The DON stated that expectations for medication change require contacting the provider and obtaining approval prior to administering the medication.