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	08/31/2023

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46578 Based on observations, staff interviews, record reviews, and a review of the facility's policies titled Peripheral Intravenous Catheter Insertion, Maintenance, and Removal, Nebulizer Therapy, and Cleaning and Disinfection of Resident-Care Items and Equipment, the facility failed to maintain infection control standard precautions by not removing an intravenous (IV) access timely after discontinuation of the IV antibiotic for one Resident (R) (#8) of three with an IV site, not keeping nebulizer mask enclosed inside a bag when not in use for one of one Resident (R) (#39), and not cleaning or disinfecting equipment between residents who were COVID-19 positive for two residents (room [ROOM NUMBER] A/B) reviewed for Transmission Based Precautions (TBP). Findings Include: 1. Review the policy titled Nebulizer Therapy revised date March 2023 revealed Section Care of the Equipment line number seven states, Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. Observation on 08/29/2023 10:20 a.m. R#39 nebulizer sitting on the side table mask not in a zip lock bag. Observation on 08/30/2023 09:20 a.m. R#39 nebulizer sitting on the side table, mask not in a zip lock bag. Observation on 8/31/2023 10:00 a.m. R#39 nebulizer sitting on the side table with mask not in a zip lock bag. Interview on 8/31/2023 at 10:08 a.m. with Certified Nursing Assistant (CNA) MM revealed she knew that respiratory equipment mask and nasal cannula (NC) should be in bags with the resident's name and date when not in use. CAN MM further stated that the staff gets respiratory education yearly and as needed or if something is new. Interview on 8/31/2023 at 10:15 a.m. with Registered Respiratory Therapist (RRT) JJ revealed masks for nebulizers and oxygen should be stored in bags with the resident's name and date. Tubing and masks should be changed every seven days. Respiratory education is upon hire, yearly, and as needed. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/31/23 at 10:20 a.m. with Certified Medication Assistant (CMA) NN revealed that she would get a new mask and tubing if she saw the mask in the room lying on the floor or the bed and put it in a bag with the resident's name and the date. Interview on 8/31/2023 at 10:25 a.m. with Licensed Practical Nurse (LPN) KK revealed that all respiratory equipment not in use should be bagged and labeled with the resident's name and date, masks, tubing, and bags should be changed every seven days. Education is completed upon hire, yearly, and as needed. Interview on 8/31/2023 at 3:30 p.m. with Regional Director of Clinical Operations revealed that she expects staff to follow doctor's orders, policy, and procedures, and treat every resident with respect and dignity. Take every complaint or situation seriously and report it to the correct person. 2. A review of the facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment dated 12/2022 revealed the Policy Interpretation and Implementation section numbered: 1.c. Non-critical items are those that encounter intact skin but not mucous membranes. (1). Non-critical resident care items include bedpans, blood pressure cuffs, crutches, and computers. (2). Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location). 1.d. Reusable items are cleaned and disinfected or sterilized between residents (such as stethoscopes, and durable medical equipment). 3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. Review of Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated May 8, 2023, revealed: Environmental Infection Control Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient. A review of the signage posted on the door of room [ROOM NUMBER] revealed signage titled Aerosol Contact Precautions with instructions that included: Use patient-dedicated or disposable equipment. Clean and disinfect shared equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/30/2023 at 10:20 a.m. of CNA LL revealed her to don personal protective equipment (PPE) and roll a vital sign monitoring machine into room [ROOM NUMBER]. Observation of the door of room [ROOM NUMBER] revealed Contact and Droplet Precautions signs on the door, and a supply of PPE was available at the doorway. At 10:33 a.m. CNA LL exited room [ROOM NUMBER] without PPE, rolled the vital signs machine into the hallway, and left it sitting in the hallway without sanitizing the machine. Continued observation at 10:35 a.m. CNA LL donned PPE and entered another room, leaving the vital sign machine in the hallway unsanitized. Interview on 8/30/2023 at 10:55 a.m. with CNA LL revealed she had worked at the facility for one year. She stated that both residents residing in room [ROOM NUMBER] were on Transmission Based Precautions (TBP) due to having a positive COVID test. CNA LL further revealed residents that who were on TBP did not have dedicated medical equipment, and staff used the same medical equipment for other residents on the unit. CNA LL stated she thought the vital sign machine was cleaned each shift by the nurses but was unsure. She stated that normally she cleaned the vital signs machine after using it for residents with a COVID diagnosis. CNA LL verified rolling the machine into room [ROOM NUMBER], using it to check vital signs for both residents in the room, removed the machine from the room, and left it in the hallway without sanitizing it. She was unsure if she had received education on sanitizing vital sign equipment or other medical equipment. Interview on 8/31/2023 at 11:15 a.m. with CNA OO revealed she has worked at the facility for three months, and received education regarding cleaning multi-use resident equipment when she was hired. CNA OO understood the education was that any resident on TBP would have dedicated equipment that stayed in the resident's room; if not, every piece of multi-use equipment must be sanitized before and after each resident and before leaving the equipment in the hall for another staff member to use. Interview on 8/30/2023 at 1:30 p.m. with the Regional Director of Clinical Operations (RDCO) revealed that there should be dedicated vital sign equipment in the rooms of residents on TBP. She also revealed that CNA LL should have sanitized the vital sign machine as soon as exiting room [ROOM NUMBER]. Finally, the RDCO revealed that the potential harm of non-compliance would be the spread of infectious diseases to staff and other residents in the facility. 46579 3. Review of the policy titled Peripheral Intravenous Catheter Insertion, Maintenance, and Removal with a revision date of August 2023, revealed that the policy of the facility to ensure that short peripheral intravenous catheters are inserted, maintained, and discontinued consistent with current standards of practice. Further review revealed that a compliance guideline for peripheral intravenous (IV) catheters is the removal of the peripheral IV is indicated by the order of the physician when therapy is complete, when clinically indicated, when deemed no longer necessary for the plan of care, or have not been used for 24 hours of more. Review of electronic medical record of resident (R) #8, revealed that resident was admitted to the facility on [DATE]. She was admitted with diagnoses that included but are not limited to diabetes, atrial fibrillation, anxiety, psychosis, dementia, and depersonalization - derealization syndrome. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly minimum data set (MDS) assessment dated [DATE], revealed that R #8 has a basic interview of mental status (BIMS) score of 9. That score means that the resident is moderately cognitively impaired. Section G of the MDS describes the amount assistance the resident needs, and review of it revealed that R # 8 needs extensive assistance with eating. Review of the care plan for R# 8, revealed that she had an increased risk for fluid volume deficit related to cognitive impairment and refusal of fluids. Interventions that are in place for this problem include but are not limited to encouraging and assisting resident with fluid intake between meals, ensure fluids are available at bedside and adequate assistance is provided for fluid intake, and IV fluids as ordered. Review of progress notes for R #8 revealed that on 8/23/2023, a change in condition was reported to the provider. The abnormal vital sign that was relayed to the provider was a blood pressure of 100/60. There were no changes noted to the mental or the functional status of the resident. The progress note review also revealed that the provider responded to the change in condition with orders for R #8 to receive two liters of sodium chloride intravenous solution 0.45% at a rate of 50 milliliters (ml)/hour (h) every shift for hydration for three days. Review of a progress note dated 8/24/2023, revealed that the IV was placed in the right forearm. Another progress note dated 8/25/2023 revealed that IV fluids were flushing and infusing without difficulty. Review of progress note dated 8/26/2023 revealed that the IV was patent, and the last bag of 0.45% normal saline was running at 50 ml/hr. The site was clean and intact, and no infiltration was noted, and flushed without issues. Review of the electronic medication administration record (eMar) for the month of August for R#8, revealed that an order for sodium chloride intravenous solution 0.45% , use 50ml/hr. intravenously every shift for hydration for three (3) days, infuse two (2) liters. Start date of 8/23/2023. It was signed off that it was started on 8/23/2023 for the evening shift and for every shift until the day shift on 8/26/2023. The review of the eMAr for R # 8 also revealed an order that read Place peripheral IV for IV fluids one time only for 3 days. The start date 8/23/2023. It was signed off as completed on 8/23/2023. An observation of R # 8 was made on 8/29/2023 at 10:15 a.m. She was observed dressed for the day, sitting in her chair. She had fresh water on her over bed table, that was within her reach. There was an Iv noted in her right forearm at this time. The resident stated that she was receiving medication for her blood in her arm. A second observation was made of R # 8 on 8/30/2023 at 11:35am. During that observation, R #8 was observed dressed for the day, in a long-sleeved shirt. Resident was sitting up in the chair. The iv in her right forearm was felt through the shirt sleeve. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:50am on 8/30/2023, an interview with Registered Nurse (RN) / Community Manager HH, revealed that she did verify that R # 8 did have an IV in her right forearm. The interview revealed that R # 8 received IV fluids and they wanted it left in until her blood pressure was high enough due to her blood pressure has been running low. She revealed that the IVs are good for a week, and we have been flushing the IV with saline. The fluids were completed on 8/26 or 8/27 I think, revealed RN HH. The completed her interview by stating that she was unsure if the order to flush the iv was on the eMAR. As the RN HH was verifying the IV in R # 8 arm was still in, she revealed that she would go ahead and discontinue it. It was at that time, she verified that the canula tip of the IV was the only part of the IV that was still in the vein in R # 8 arm. Review of the progress notes revealed there was no progress note for R # 8 since 8/26/2023. An interview with licensed practical nurse (LPN) II was conducted on 8/30/2023 at 12:13 pm. She revealed that she was the nurse that was watching the certified medication aide that was responsible for R # 8's medications. She revealed that she was unaware that R # 8 had an IV and therefore, she had not flushed it. Review of the progress note dated 8/30/2023 revealed that R #8 Iv was discontinued per physician orders. On 8/31/2023 at 2:20pm, LPN CC was interviewed. She revealed that nurses would need an order for the IV and the fluids that would include the type of fluids and the rate, and the duration. She also revealed that if the fluids is not continuous, then there will need to be an order for flushes, that would be on the eMAR for the nurse to sign off when it is completed. She stated that once the infusion has been completed for its ordered duration, the nurse would need to obtain an order to discontinue the IV. An interview on 8/31/2023 at 3:37pm with the RN/ Regional Nurse Consultant, revealed that it is the expectation that IV be removed at the completion of the IV therapy.