STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Health and Rehabilitation	**625 Ashland Street , Archdale, North Carolina, 27263**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 5/20/26 to 5/21/26. Event ID# 232BA5-H1. The following intakes were investigated 2977141, 3014342, and 3017958. 1 of the 8 complaint allegations resulted in deficiency.	F0000		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff, Pharmacy Consultant, and Medical Director interviews, the facility failed to administer scheduled medications as ordered by the physician for 6 of 32 residents on the D and E halls that were reviewed for medication administration (Residents #4, #5, #6, #7, #8 and #9). The findings included: A. Resident #4 was admitted to the facility on 1/15/25 with diagnoses that included Parkinson's disease with dyskinesia (a movement disorder defined by involuntary and uncontrollable muscle movements). Review of the active physician orders included the following orders: - An order dated 1/15/25 for ropinirole (a medication used to improve muscle control and manage movement) 0.25 milligrams (mg). Give one tablet by mouth three times a day for Parkinson's disease. - An order dated 1/16/25 for Benztropine Mesylate (a medication used to reduce muscle stiffness, body	F0658	Upon identification of the deficient practice, the facility immediately reviewed the medication administration records and physician orders for Residents #4, #5, #6, #7, #8, and #9 to determine the medications that were not administered as ordered on 5/16/2026. Residents residing on D and E halls were assessed for any adverse outcomes related to the interruption in medication administration coverage, and no adverse outcomes were identified. The attending Medical Director reviewed the omitted medications on 5/21/2026 and determined that none of the medications were considered significant, no additional orders were received, and no adverse outcomes were identified. All residents had the potential to be affected by the deficient practice. On 5/21/2026, the Director of Nursing or designee reviewed medication administration records, nursing documentation, staffing schedules, and assignment sheets for the previous thirty days to identify any additional medication omissions or trends related to assignment coverage. No additional concerns were identified. On 5/21/2026, the facility implemented a process requiring immediate notification to nursing leadership whenever a medication administration assignment cannot be covered as scheduled. Staff assigned medication administration responsibilities will not leave an assignment without providing a verbal handoff and ensuring the assignment has been accepted by another qualified individual and approved by nursing leadership. Unexpected staffing concerns affecting medication administration will be immediately communicated to the Director of Nursing and Administrator for escalation and implementation of contingency staffing measures.	06/10/2026

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 reverse for further 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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F0658 SS = E	Continued from page 1 spasms and tremors) 0.5 mg. Give one tablet by mouth in the afternoon for dyskinesia. - An order dated 1/6/25 for Sinemet (a medication used to treat Parkinson's disease) 25-100 mg. Give one tablet by mouth four times a day for Parkinson's disease. Review of the May 2026 Medication Administration Record (MAR) indicated Resident #4 did not receive ropinirole 0.25 mg at 1:00 PM, Benztropine Mesylate 0.5 mg at 1:00 PM or Sinemet 25-100 mg at 2:00 PM on 5/16/26. B. Resident #5 was admitted to the facility on 11/20/25 with diagnoses that included congestive heart failure and hypertension. Review of the active physician orders revealed an order dated 12/16/25 for hydralazine (a medication used to treat high blood pressure) 10 mg. Give one tablet by mouth three times a day for essential hypertension. Hold for systolic blood pressure (the top number of the blood pressure reading) less than 110. Review of the May 2026 MAR indicated that Resident #5 did not receive hydralazine 10 mg at 2:00 PM on 5/16/26. C. Resident #6 was admitted to the facility on 7/17/23. Her diagnoses included bipolar disorder. A review of the active physician orders included the following orders: - An order dated 4/3/26 for buspirone (a medication used to treat chronic anxiety) 15 mg. Give one tablet by mouth three times a day for anxiety. - An order dated 5/16/26 for depakote sprinkles (a medication used as a mood stabilizer) 125 mg. Give two capsules by mouth in the afternoon for bipolar disorder. Review of the May 2026 MAR revealed Resident #6 did not receive buspirone 15 mg or depakote sprinkles 125 mg at 2:00 PM on 5/16/26.	F0658	Continued from page 1 Coverage resources include available licensed nurses, medication aides, Unit Managers, and facility leadership to ensure continuous nursing services and medication administration. On 5/21/2026, the Administrator and Interim Director of Nursing educated 100% of licensed nurses, medication aides, Unit Managers, the Staffing Scheduler, and facility leadership members regarding medication administration coverage expectations, communication requirements, assignment accountability, handoff expectations, and notification requirements. On 6/2/2026, an Ad Hoc Quality Assurance and Performance Improvement meeting was conducted with the Interdisciplinary Team to review the circumstances surrounding the deficient practice, identify opportunities for improvement, and implement processes to ensure medication administration assignments are appropriately communicated and covered. The education regarding assignment accountability, communication expectations, and notification requirements will be incorporated into new employee orientation and ongoing staff education by the Director of Nursing or designee. The Director of Nursing or designee will audit medication administration records, staffing assignments, and assignment coverage daily for four weeks, then five times weekly for four weeks, and then weekly for four weeks to ensure medication administration assignments are appropriately covered and medications are administered as ordered. Variances identified during the audit process will be corrected promptly and additional education provided as indicated. The Director of Nursing or designee will present the results of the audits and any identified trends to the monthly Quality Assurance and Performance Improvement Committee for three months for review and recommendations as indicated. Any findings identified through medication administration audits, staffing reviews, assignment coverage reviews, or medication pass observations will be reviewed by the Quality Assurance and Performance Improvement Committee, and additional corrective actions will be implemented as necessary to ensure ongoing compliance. Compliance Date: June 10, 2026.	06/10/2026

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F0658 SS = E	Continued from page 2 D. Resident #7 was admitted to the facility on 7/19/21 with diagnoses that included rheumatoid arthritis and polyneuropathy. A review of the active physician orders included an order dated 12/10/25 for Acetaminophen (a medication used to treat mild-to-moderate pain) 650 mg by mouth three times a day for acute and chronic pain/back pain. The May 2026 MAR was reviewed and revealed Resident #7 did not receive Acetaminophen 650 mg at 1:00 PM as ordered on 5/16/26. E. Resident #8 was admitted to the facility on 7/6/22 and had diagnoses that included primary open-angle glaucoma of the right eye, other corneal scars and blindness to the right eye. A review of the active physician orders included an order dated 9/5/24 for dorzolamide (a medication used to lower high pressure inside the eye) ophthalmic solution 2%. Instill one drop in both eyes every 8 hours for glaucoma. The May 2026 MAR was reviewed and indicated that Resident #8 did not receive dorzolamide eye drops as scheduled at 2:00 PM on 5/16/26. F. Resident #9 was admitted to the facility on 3/1/25 with diagnoses that included fibromyalgia, bilateral primary osteoarthritis of the knee and polyneuropathy. The active physician orders included an order dated 11/18/25 for Acetaminophen (a medication used to treat mild-to-moderate pain) 325 mg. Give two tablets by mouth three times a day for chronic pain. A review of the May 2026 MAR indicated that Resident #9 did not receive Acetaminophen at 1:00 PM on 5/16/26. An interview occurred with Nurse #1 on 5/20/26 at 2:55 PM, who indicated that she had worked from 7:00 AM to 7:00 PM on 5/16/26. She stated after	F0658		06/10/2026

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F0658 SS = E	Continued from page 3 12:45 PM, there were only two nurses (Nurse #2 and herself) in the facility to administer medications due to Medication Aide (MA #1), who was assigned to D and E halls, leaving. Nurse #1 stated there was no effort from MA #1 to provide report or hand off the assignment when she left at 12:45 PM, and additionally she felt uncomfortable being responsible for an additional assignment. Nurse #1 stated she texted the Administrator and interim Director of Nursing (DON) in a group text regarding the staffing situation that morning and again at 12:45 PM, when MA #1 left and was told by the Administrator that they were working on finding a replacement and that medications were caught up till 5:00 PM. Nurse #1 stated that she did not administer any medications to the D and E hall residents from 1:00 PM to 5:00 PM. Nurse #1 indicated that Unit Manager #1 arrived at the facility shortly after 5:00 PM as the replacement for MA #1. Nurse #2 was interviewed on 5/20/26 at 3:08 PM and stated that she worked from 7:00 AM to 7:00 PM on 5/16/26. She stated that MA #1 left around 12:45 PM, leaving only two nurses in the facility to administer medications (Nurse #1 and herself). She recalled MA #1 stated she was only working four hours and made no effort to hand off the assignment when she left at 12:45 PM, for the D and E hall residents. Nurse #2 added that she was uncomfortable being responsible for an additional assignment. Nurse #2 stated that she was aware Nurse #1 had been texting with the Administrator and interim DON regarding the staffing issue and was advised they were working on a replacement for MA #1. Nurse #2 stated that she did not administer any medications to the D and E hall residents from 1:00 PM to 5:00 PM. Nurse #2 stated that Unit Manager #1 was present at the facility at 5:00 PM as a replacement for MA #1. MA #1 was interviewed on 5/20/26 at 3:20 PM and explained that her primary job duty was as medical records during the week, but she assisted as a MA when needed. She stated that on 5/16/26 she was the manager on duty for four hours and arrived at the facility at 7:30 AM. She was contacted by the staffing scheduler close to 8:00 AM and was asked if she could cover the medication cart for D and E halls. She agreed and verified there were two nurses in the facility at that time. MA #1 stated that she left at 12:45 PM saying, “All knew that I was working four hours since I was the manager on duty”. MA #1 stated that at 12:45 PM, she told the two nurses her time was up and left. MA #1 stated she reached out	F0658		06/10/2026

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F0658 SS = E	Continued from page 4 to the Staffing Scheduler and the Administrator and was told they were working on finding a replacement. MA #1 stated that no one would take her assignment from her. MA #1 further stated that she provided the morning and any lunch time medications that were ordered for residents on the D and E halls on 5/16/26. MA #1 stated that if a medication was not signed out as given at 1:00 PM or 2:00 PM for any resident on D or E hallway, then she didn't provide it to them on 5/16/26. On 5/20/26 at 3:29 PM, an interview was conducted with Unit Manager #1, who recalled she had been called by the Administrator in the afternoon of 5/16/26 and asked if she could cover a medication cart. She let him know that she could be there at 5:00 PM and worked the D and E hall medication cart on 5/16/26 from 5:00 PM to 7:00 PM. An interview occurred with the Staffing Scheduler on 5/20/26 at 3:36 PM, who explained that MA #1 was the manager on duty on 5/16/26, knew she would be at the facility, and asked her if she could cover the D and E hall medication cart that morning. The Staffing Scheduler indicated MA #1 was "not prepared" to stay for a full shift. She indicated that both the interim DON and Administrator were aware and that attempts to find a replacement for MA #1 were made. The Staffing Scheduler verified Unit Manager #1 was able to come in the facility at 5:00 PM on 5/16/26 and between 1:00 PM and 5:00 PM two nurses were in the facility. A phone interview was conducted with the Pharmacy Consultant on 5/21/26 at 11:35 AM and reviewed medications that were missed on 5/16/26 for Residents #4, #5, #6, #7, #8 and #9. He stated that none of the medications that were not provided on 5/16/26 were considered significant. The Medical Director was interviewed via phone on 5/21/26 at 4:30 PM and reviewed #4, #5, #6, #7, #8 and #9's medications that were not provided on 5/16/26. She stated that she did not consider any of the medications not provided as significant as most of them were provided at other times during the day or the next day. She added that missing a single dose of medication in many chronic conditions would not have resulted in adverse outcomes. A phone interview was completed with the interim	F0658		06/10/2026

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F0658 SS = E	Continued from page 5 DON on 5/21/26 at 12:39 PM, who explained she started at the facility on 5/14/26. The interim DON stated that MA #1 should have taken every opportunity to hand off her assignment on 5/16/26 before leaving the facility at 12:45 PM or have reached out to her (interim DON) if there was an issue. The interim DON added that she was unaware there were issues with nurse staffing on 5/16/26 or she would have come into the facility and taken the assignment for the D and E hall medication cart until a replacement could be secured. A phone interview occurred with the Administrator on 5/21/26 at 12:55 PM and stated that he initiated asking MA #1 to assist with the D and E hall medication cart on 5/16/26 as he knew she would be at the facility as the manager on duty and was aware that she could only work for approximately four hours. The Administrator stated that both he and the Staffing Scheduler were calling staff for a replacement for MA #1 and that he “was aware there would be a medication pass in the evening around 5:00 PM. The Administrator indicated he was trying to recruit someone to come in for that afternoon medication pass” and wasn’t aware there were residents with medications ordered between 1:00 PM and 5:00 PM. The Administrator added that he thought the two nurses on duty 5/16/26 from 7:00 AM to 7:00 PM would’ve covered the medication cart for any needed medications until the replacement arrived and was not aware that some of the resident’s on the D and E halls did not receive their medications as ordered.	F0658		06/10/2026
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff.	F0725	Upon identification of the deficient practice, the facility immediately reviewed staffing coverage, medication administration records, and assignment responsibilities related to the events of 5/16/2026. Residents residing on D and E halls were assessed for any adverse outcomes related to the interruption in medication administration coverage, and no adverse outcomes were identified. The attending Medical Director reviewed the omitted medications on 5/21/2026 and determined that none of the medications were considered significant, no additional orders were received, and no adverse outcomes were identified. All residents had the potential to be affected by the deficient practice. On 5/21/2026, the Director of Nursing or designee reviewed medication administration records, nursing documentation, staffing schedules, and assignment sheets for the previous thirty days to identify any additional	06/10/2026

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F0725 SS = E	Continued from page 6 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Pharmacy Consultant, Medical Director and staff interviews, the facility failed to ensure there was sufficient nursing staff in the facility on 5/16/26 from 1:00 PM to 5:00 PM to administer medications as ordered to the D and E halls for 6 of 32 residents reviewed for medication administration (Resident's #4, #5, #6, #7, #8 and #9). The findings included: This tag is cross referenced to: F658: Based on record reviews, Pharmacy Consultant, Medical Director and staff interviews, the facility failed to administer scheduled medications as ordered by the physician for 6 of 32 residents on the D and E halls that were reviewed for medication administration. (Residents ##4, #5, #6, #7, #8 and #9). The facility's daily assignment sheet dated 5/16/26 revealed the following nursing staff were scheduled to work during the day shift (7:00 AM to 7:00 PM) for medication administration. Nurse #1 was assigned to work on the A and F halls from 7:00 AM to 7:00 PM), Nurse #2 was assigned to work on the B and C halls from 7:00 AM to 7:00 PM, Medication Aide (MA) #1 was assigned to work on the D and E halls from an unknown time and Unit Manager #1 was assigned to work on the D and E halls from an unknown time.	F0725	Continued from page 6 medication omissions or trends related to assignment coverage. No additional concerns were identified. On 5/21/2026, the facility implemented a process requiring immediate notification to nursing leadership whenever a medication administration assignment cannot be covered as scheduled. Staff assigned medication administration responsibilities will not leave an assignment without providing a verbal handoff and ensuring the assignment has been accepted by another qualified individual and approved by nursing leadership. Unexpected staffing concerns affecting medication administration will be immediately communicated to the Director of Nursing and Administrator for escalation and implementation of contingency staffing measures. Coverage resources include available licensed nurses, medication aides, Unit Managers, and facility leadership to ensure continuous nursing services and medication administration. On 5/21/2026, the Administrator and Interim Director of Nursing educated 100% of licensed nurses, medication aides, Unit Managers, the Staffing Scheduler, and facility leadership members regarding medication administration coverage expectations, communication requirements, assignment accountability, handoff expectations, and notification requirements. On 6/2/2026, an Ad Hoc Quality Assurance and Performance Improvement meeting was conducted with the Interdisciplinary Team to review the circumstances surrounding the deficient practice, identify opportunities for improvement, and implement processes to ensure medication administration assignments are appropriately communicated and covered. The education regarding assignment accountability, communication expectations, and notification requirements will be incorporated into new employee orientation and ongoing staff education by the Director of Nursing or designee. The Director of Nursing or designee will audit medication administration records, staffing assignments, and assignment coverage daily for four weeks, then five times weekly for four weeks, and then weekly for four weeks to ensure medication administration assignments are appropriately covered and medications are administered as ordered. Variances identified during the audit process will be corrected promptly and additional education provided as indicated.	06/10/2026

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F0725 SS = E	Continued from page 7 The daily nurse staff posted report dated 5/16/26 indicated the resident census was 65. A review of the payroll time reports for 5/16/26 were reviewed and revealed MA #1 clocked in for the shift on 5/16/26 at 7:29 AM and clocked out for the day at 12:54 PM. Unit Manager #1 clocked in for the shift on 5/16/26 at 5:10 PM and clocked out at 7:35 PM.	F0725	Continued from page 7 The Director of Nursing or designee will present the results of the audits and any identified trends to the monthly Quality Assurance and Performance Improvement Committee for three months for review and recommendations as indicated. Any findings identified through medication administration audits, staffing reviews, assignment coverage reviews, or medication pass observations will be reviewed by the Quality Assurance and Performance Improvement Committee, and additional corrective actions will be implemented as necessary to ensure ongoing compliance. Compliance Date: June 10, 2026.	06/10/2026