**NAME OF PROVIDER OR SUPPLIER**

WESTFIELD REHABILITATION AND HEALTH CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3100 TRAMWAY ROAD
SANFORD, NC 27330

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>ID</th>
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<td>INITIAL COMMENTS</td>
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The follow up has been completed and the facility is back in compliance effective 5/15/19.

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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed

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.