

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Westwood Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Fletcher Street Wilkesboro, NC 28697	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Westwood Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Fletcher Street Wilkesboro, NC 28697	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with resident, staff, Pharmacy Manager and the Medical Director, the facility failed to implement effective systems to safeguard a resident's controlled medication from misappropriation (30 tablets of oxycodone 15 milligrams) for 1 of 1 resident reviewed for misappropriation of property (Resident #22). The findings included: Resident #22 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome. Review of Resident #22's physician orders dated 10/30/24 revealed an order for oxycodone 15 mg by mouth every six hours for pain. Review of Resident #22's Medication Administration Record for 08/2025 revealed he was given oxycodone 15 mg by mouth every six hours as ordered. Review of a pharmacy packing slip revealed Resident #22's oxycodone 15 mg /120 tablets were delivered to the facility on [DATE] and were counted in by Nurse #3 and Nurse #4. The packing slip indicated the count was correct. Review of Resident #22's quarterly Minimum Data Set assessment dated [DATE] indicated the Resident was cognitively intact and received routine pain medication. An interview was conducted with Resident #22 on 11/16/25 at 1:15 PM. The Resident explained that he was in chronic pain all the time and received routine pain medication to help control his pain. He stated that the facility provided his pain medication and he had never run out of pain medication. Review of an Occurrence Investigation Report Summary dated 09/12/25 revealed Resident #22 was ordered oxycodone 15 mg by mouth every six hours. The facility received the Resident's medication from the pharmacy on 08/19/25 of 4 cards of 30 tablets each card for a total of 120 tablets. The order was verified and signed in by two licensed nurses per protocol. The medication was not started until 08/21/25 due to the Resident already having some oxycodone 15 mg tablets on the cart from a previous order. On 09/11/25 the nurse notified the Director of Nursing (DON) that Resident #22 only had two tablets of oxycodone 15 mg left so the DON contacted the pharmacy and was informed that Resident #22 should have enough oxycodone tablets to get through the following week because they sent 120 tablets of oxycodone for the Resident on 08/18/25. The DON immediately reviewed the previous packaging slip and verified that 120 tablets had been verified and signed in by nursing staff on 08/19/25. The DON verified Resident #22's Medication Administration Record that the Resident had not missed any doses and verified one card in the cart labeled #4 of 4 with 2 tablets remaining in the card. The declining count sheet for the oxycodone matched with 2 tablets remaining. The DON then pulled all Resident #22's declining count sheets for the oxycodone that was received on 08/19/25 and discovered that the declining count sheet for card #3 of 4 was missing. The DON pulled the Shift Change Controlled Substance Count Check Form (a count sheet utilized between shifts to indicate the controlled medication cards and declining count sheets match and were correct) for the 100-hall medication cart from July to present and discovered that the sheet from dates 08/16/25 through 08/22/25 was also missing. The DON pulled the packing slip for the previous order of oxycodone for Resident #22 which was 07/17/25 to verify the number of tablets received and signed in and the count was correct. There were no concerns identified. Review of a Pharmacy memo to the facility dated 09/12/25 indicated that the facility was charged for 60 tablets of oxycodone 15 mgs each for Resident #22. Review of a Drug Enforcement Administration form dated 09/14/25 revealed the facility reported the loss or theft of 30, 15 mg oxycodone hydrochloride tablets. Review of the Investigation Report dated and faxed to the Health Care Personnel Registry on 09/18/25 revealed that on 09/12/25 at 9:00 AM the facility became aware of 30, 15 mg oxycodone tablets were missing for Resident #22. The Report indicated that the local police were notified of the missing narcotics on 09/12/25 at 6:30 PM and the Department of Social Services was notified on 09/12/25 as well. The Report continued to explain that the investigation could not confirm a person took the medication therefore, drug diversion could not be confirmed. Also, it was not known whether the pill pack was thrown in the trash mistaken for an empty card. The allegation was not substantiated for drug diversion. Review of Resident #22's Controlled Substance Count Records (declining count sheet) revealed the following: declining count sheet #1 was initiated on 08/21/25 with 30 tablets and exhausted to 0 tablets on 08/28/25. Declining count sheet #2 was initiated on 08/28/25 with 30 tablets and exhausted to 0 tablets on 09/04/25 and declining count sheet #4 was initiated on 09/05/25 with 30 tablets and exhausted to 2 tablets on 09/11/25. There was no record of declining count sheet #3. Review of the Shift Change Controlled Substance Count Check Form for 100 hall revealed the Shift Change Count Sheet for the dates of 08/16/25 through 08/22/25 was missing. An interview was conducted with the Director of Nursing (DON) on 11/17/25 at 2:15 PM. The DON explained that she was notified on the afternoon of 09/11/25 by Nurse #1 that</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345205	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Westwood Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Fletcher Street Wilkesboro, NC 28697	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interviews, the facility failed to remove 63 expired nutritional shakes from their dry storage area which resulted in 3 of the expired nutritional shakes making it to the service line and prepared for service to residents. The findings included: An observation made of the facility's dry storage area on 11/16/25 at 9:50 AM revealed 48 mixed berry flavored nutritional supplement shakes with an expiration date of 08/01/25 and 18 vanilla flavored nutritional shakes, with an expiration date of 06/20/25, sitting in the dry storage room on the top shelf. A follow-up observation of the kitchen, completed on 11/18/25 at 12:21 PM revealed the 48 mixed berry nutritional supplements with an expiration date of 08/01/25 to still be on the shelf in the dry storage area. However, there were only 15 vanilla flavored nutritional supplements with an expiration date of 06/20/25 in the dry storage area. An observation of the tray service line on 11/18/25 at 12:25 revealed 3 vanilla flavored nutritional shakes with an expiration date of 06/20/25 to be in an ice bin on the service line, ready to be served. The surveyor intervened and removed the expired nutritional shakes from the service line to prevent them from being served to residents. A brief interview with the Assistant Dietary Manager on 11/18/25 at 12:27 PM revealed she believed she had checked all of the nutritional shakes earlier that week but stated she must have missed a few and that the expiration dates should have been checked when she pulled them from the back to place them on the service line. She also indicated that food items were checked as new food stock arrived at the facility. An interview with the Dietary Manager on 11/19/25 at 9:54 AM revealed the facility must have ordered too many nutritional shakes and not enough residents in the facility were drinking them. He also stated the facility's process for ensuring that expired food was removed from stock included checking the food items twice a week, usually when the new food stock comes into the facility. He reported the kitchen storage areas were small and the facility typically ordered enough food to fix the meals scheduled until the next food order arrived. He reported he expected his staff to remove expired food items as they expired and indicated there was no reason for the nutritional shakes to have been overlooked for so long. The Dietary Manager stated the responsibility ultimately belonged to himself to ensure that there were no expired food items in the kitchen. An interview with the Administrator on 11/19/25 at 1:24 PM revealed he did not have many residents in the facility that used nutritional shakes but there was no reason why so many expired nutritional shakes were still in the dry storage area. He also indicated the no expired food items should make it to the service line.</p>