STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westfield Rehabilitation and Health Center	3100 Tramway Road Sanford, NC 27330

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident interview and staff interviews, the facility failed to perform a transfer from the bed to wheelchair in a safe manner for 1 of 3 residents reviewed for accidents (Resident #26). Resident #26 had pain and sustained a skin tear (laceration) to midline shin (the front of the leg below the knee) with significant depth to left lower leg which required a visit to the emergency department and sutures. Findings included: Resident #26 was admitted to the facility on [DATE] with the diagnoses that included hypertension, hyperlipidemia, polyneuropathy and anemia. The admission Minimum Data Set Assessment (MDS) dated [DATE] revealed that Resident #26 was coded as cognitively intact, required wheelchair for mobility, required partial/moderate assistance for a chair-to-bed transfer. On the same assessment, she was also coded as requiring supervision or touching assistance with personal hygiene. Documentation on Resident #26's care plan initiated on 8/6/2025 revealed a focus area of Activities of Daily Living (ADL) self-care performance deficit due to impaired, limited mobility, limited Range of Motion (ROM), musculoskeletal impaired and pain. The care plan revealed Resident #26 required the intervention of 2-person assistance with transfers. Review of undated Kardex (a quick- reference tool that provides a concise summary of a patient's essential information and daily care needs for handoff between nursing shifts) report revealed Resident #26 require 2-person assistance with transfers. Review of the transfer status form for Resident #26 dated 08/08/2025 revealed her transfer status was maximum assistance with 2-person assist due to limited shoulder pain. Review of the August 2025 Medication Administration Record (MAR) revealed Resident #26 was not prescribed an anticoagulant medication. Review of the incident report dated 08/08/2025 documented Resident #26 sustained skin tear during transfer from bed to wheelchair. Resident #26 stated she told Nurse Aide (NA) #1 to stop when being transferred because she was hurting her and that she required assist of 2 however NA #1 continued to transfer her. It documented Resident # 26 was transferred to the emergency department for further evaluation. NA #1 was immediately suspended pending investigation. Review of NA #1's statement dated 08/08/2025 revealed she was getting the patient up out of bed, the resident was able to turn and sit on the side of bed, and the resident stated sometimes it took two people to get her up. NA #1 told the resident that she was able to do it alone. During a phone interview on 08/19/2025 at 11:55AM, NA #1 stated another staff told her several times to get Resident #26 up so she could go to therapy. NA #1 stated she proceeded to get the resident up without asking for assistance from another staff member. She stated during the transfer of the resident her lower leg bumped on the wheelchair, and the leg started bleeding. NA #1 stated she did not review the Kardex which indicated the resident needed 2-person assistance for transfer. She added that she realized the resident required 2-person assistance after the skin tear accident. NA #1 stated the resident appeared very fragile and she felt that she could transfer her without assistance from another staff member from bed to her wheelchair. Review of skin tear assessment for Resident #26 dated 08/08/2025 revealed the site of left lower leg (front). It documented skin tear laceration, heavy bleeding and pressure applied. Exact measurements could not be obtained. Resident #26 wound was dressed and cleansed for transport to emergency room (ER) per Medical Doctor's (MD) order for further evaluation. The review of the assessment revealed the resident was given Acetaminophen (pain medication) 325 milligrams (mg) 2 tablets for pain. During an interview on 08/19/2025 at 1:28PM, Nurse #2 stated she was notified about Resident #26's skin tear on 08/08/2025. She stated she observed the resident was bleeding with a deep cut. She added she applied pressure on the deep cut to stop bleeding. She reported the bleeding was heavy, the provider was notified, and he ordered the resident to be sent to the Emergency Department. Review of the Emergency Department (ED) note dated 08/08/2025 documented the chief complaint was the resident was taken to ED after getting small laceration to left shin due to hitting it on a wheelchair. The resident was given (pain medication) enroute to the ED. The note documented a skin tear- about 6 centimeters (cm) to left lower leg which was bleeding, had controlled distal pulses (a pulse felt in an artery located further away from heart) capillary refill and had no neurovascular (the interconnected of nerves and blood vessels) deficits. ED note also documented the medical decision described the resident as coming to the ED with skin tear and laceration to left lower leg, which was repaired using sutures, irrigated and dressed by the provider. Review of the Health Status note dated 08/11/2025 by Nurse #2 documented procedural notes post ED visit for laceration management obtained. Three sutures internal placement will dissolve, (Bandage) placed. Light amount serosanguinous drainage noted. Physician