STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. Building B. Wing	11/07/2025

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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to protect a resident's right to be free from resident to resident sexual abuse when Medication Aide #2 observed Resident #1, a male resident, fondle a severely cognitively impaired female resident (Resident #2) when he lifted both of Resident #2's breasts out of the neckline of her V-neck shirt and caressed them with both hands and when Medication Aide #1 observed Resident #1 holding the hand of Resident #2 and rubbing her hand over his pants in his crotch area. Resident #2 did not have the cognitive capacity to consent to this intimate sexual contact. This deficient practice affected 1 of 3 residents reviewed for resident-to-resident abuse (Resident #2).The findings included:A. Resident #1 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, diabetes mellitus, coronary artery disease, cognitive communication deficit and a history of a cerebral infarction (a condition where blood flow to the brain in interrupted leading to brain tissue damage) with residual right side hemiparesis (weakness on one side of the body). A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was moderately cognitively impaired. Resident #1 propelled himself independently in his wheelchair.A review of Resident #1's care plan dated 7/31/2025 indicated the resident had no care plan related to sexually inappropriate behaviors as of 10/4/2025.Resident #2 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's dementia, and adult failure to thrive. A quarterly MDS assessment dated [DATE] indicated Resident #2 was severely cognitively impaired. Resident #2 was severely impaired in the area of daily decision making, she could feed herself with set up/supervision but otherwise required total assistance with all Activities of Daily Living (ADL). Resident #2 was dependent on staff for mobility and transfers to the geriatric recliner.A late entry nursing progress note dated 10/6/2025 at 1:17 AM created by the Weekend Nursing Supervisor #1 indicated on 10/4/2025 she had been told by Medication Aide #2 that Resident #1 had pulled Resident #2's breasts out of her V-neck shirt and was touching them. Staff had separated the residents. Resident #2 was laughing and Resident #1 was stating What did I do?. Emotional support was provided to Resident #2. The Administrator, Director of Nursing (DON), Medical Director, Residents' Responsible Parties, Mental Health Provider, Weekend Triage Nurse Practitioner, local law enforcement, and Adult Protective Services (APS) were notified. Resident #1 was started on Prozac, 10 milligrams (mg) capsule by mouth at bedtime for 7 days then increase Prozac to 20 mg by mouth at bedtime. (Prozac is a prescription drug used to treat a variety of mental health conditions. It works by increasing the levels of serotonin, a neurotransmitter that helps regulate mood, emotion and sleep. The side effect of decreased sexual drive is helpful in managing compulsive sexual behavior). A complete blood count (CBC) was ordered for Resident #1 with no abnormal findings. Resident #1 remained on one to one supervision until 11:00 PM on 10/4/2025 then every 15 minute checks were started. A review of the 24-hour Initial Report dated 10/4/2025 at 3:00 PM indicated that staff had notified the Administrator that a male resident (Resident #1) had been observed fondling a female resident (Resident #2). The staff immediately separated the residents. Both residents were assessed and no injuries noted. Resident #1 was placed on one to one supervision. The provider and responsible parties were notified. Local law enforcement was contacted on 10/4/2025 at 4:10 PM. The State Agency was notified on 10/4/2025 at 3:05 PM. The initial report was signed by the Administrator.A review of a local Law Enforcement Incident Report dated 10/4/2025 at 4:41 PM revealed the officer responded to a call in reference to assault with sexual motive between residents. No charges were filed or further action taken.A review of a Nurse Practitioner (NP) note dated 10/6/2025 at 6:19 PM indicated Resident #1 was seen due to inappropriate touching of another resident over the weekend. Psychiatry services were contacted and Prozac was started on 10/4/2025. Resident #1 frequently refused medication and had ongoing behaviors. Recommendations were to increase supervision, redirect inappropriate behavior, continue medications as ordered and encourage compliance and maintain regular psychiatry/psychology follow-up.A review of the 5 Day Investigation summary dated 10/10/2025 indicated staff reported on 10/4/2025 at 2:40 PM that Resident #1 was in his wheelchair and approached Resident #2 seated in a geriatric recliner at the nurses' station. Without warning Resident #1 lifted Resident #2's breasts out of her shirt and began fondling them. Staff immediately separated the residents. During the separation, Resident #1 attempted to hit and bite staff. Both residents were assessed and no injuries noted. Resident #1 was placed on one to one supervision. Local law enforcement arrived at approximately 4:40 PM. No further legal action was anticipated. APS was notified via 911 at 5:11 PM and the APS case worker