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	02/19/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, resident, and staff interviews, the facility failed to treat a resident in a dignified manner when there was a delay in answering a resident ‘s call light for 1 of 4 residents (Resident #21) reviewed for dignity.The findings included:Resident #21 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus, acute arterial ischemic stroke, multifocal, bipolar I disorder, current manic with psychotic features and Schizophrenia.Resident #21's admission care plan dated 01/23/26 did not have a focus area for behaviors.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #21's cognition was intact. Resident #21 required moderate assistance by staff with oral hygiene, ambulating 10 feet, chair/bed to chair transfers, and personal hygiene, maximum assistance by staff with upper body dressing, bed mobility, and toileting transfers, and he was dependent on staff for toileting hygiene, and to shower/bathe self. A continuous observation was completed on 02/16/26 from 11:10 AM until 11:31 AM of Resident #21's call light being on and he was yelling for assistance. (Hey, someone help me, hey come here, I need help.) At approximately 11:16 AM This surveyor was at the doorway of Resident #21's room and advised him I would get him some assistance. Nursing Assistant (NA) #3 was in the room next door to him. She stated she would get to him as soon as possible. Resident #21 started yelling out again and continued to do so until approximately 11:30 AM this surveyor went to the nurses' station where 5 staff members (Medication Aide (MA) #2, Human Resource Coordinator/Nursing Assistant (NA), Nurse #2, NA #4, and NA #5) were at. The nursing staff acknowledged the call bell being on, but they did not know how long it had been on. The call light was observed and heard at the beginning of the hall in front of nurses' station. This surveyor asked the staff if they assisted with answering call lights, MA #2 stated oh he does that, he yells out for assistance, however she did not go to assist Resident #21. Human Resource Coordinator/NA was passing this surveyor approached the nurses' station to assist Resident #21. MA #2 then stated, I don't know I just got up here. This surveyor asked the staff two more times if they assisted with answering call lights, Nurse #2, NA #4, and NA #5 did not respond to this surveyors' questions. An interview was conducted on 02/16/26 at 11:16 AM with Resident #21. He was yelling out Hey, someone help me, hey come here, I need help. This surveyor approached Resident #21's room at the door and advised him I would get him some assistance. Resident #21 stated he had been yelling for assistance for approximately 30 minutes, and no one had come to his room. Resident #21 stated he can see the time on his television and that was how he tracked how long it would take staff. He explained this occurred all the time and it did not matter what concern he needed. He indicated this time he needed to be up for therapy. He went on to say he would wait for up to an hour or more waiting for staff to answer his call light but they just don't care. He then stated it made him upset and frustrated when the staff don't answer his call light.An interview was conducted on 02/18/26 at 4:02 PM with the Director of Nursing (DON). The DON stated she was unaware of the (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wait times and staff not answering Resident #21's call bell. She was aware that Resident #21 would yell out, scream, and use his call light for assistance. She explained that Resident #21 had mental health conditions that sometimes affected his sense of time. She also stated her expectations were for the call lights to be answered by all staff.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, friend and staff and local Law Enforcement Officer interviews, the facility failed to protect a resident's right to be free from misappropriation of resident's property. This affected 1 of 1 resident reviewed for misappropriation (Resident #19).The findings included: Resident #19 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #19 to be cognitively intact without behaviors. An initial allegation report was received by the State Agency from the facility's former Director of Nursing (DON) #2 on 8/29/25 at 4:15 PM. The report read that the facility initially became aware of the incident on 8/29/25 at 4:00 PM and alleged notification that Nurse #1 received a truck bed from Resident #19 with a BIMS of 12 (this score of 12 indicates the resident was cognitively intact). Resident's contact person notified staff that Nurse #1 was not supposed to receive the truck bed or any other of the items in her possession. Police were notified, and the facility investigation was initiated. The incident was reported to local law enforcement on 8/29/25 at 4:15 PM. Nurse #1 was interviewed on 2/17/26 at 12:27 PM and reported she was in Resident #19's room speaking with him and his Friend back in August 2025 when the conversation came up that she needed another vehicle. Nurse #1 stated the Friend told her they had a car they were selling at an auction that she could go and look at to see if she was interested in purchasing it. Nurse #1 stated she went to look at the car and realized the vehicle needed a lot of work done on it, so she was not interested in purchasing it. Nurse #1 stated there was also a truck bed they all discussed so she asked her mechanic to go and look at it to see if it could be used and turned into a bed for her home. Nurse #1 stated she did not ask him to pick it up for her but only asked him to look at it to see if she wanted to buy it. Nurse #1 reported her mechanic took it upon himself to pick it up and bring it to her house. She reported she did not ask him to do that, but he did it anyway. Nurse #1 reported Resident #19's Friend wanted it back, so she put a tarp over it, and it sat in her yard for 2 months before the Friend had it picked up. Nurse #1 reported that she did contact the Friend about returning the truck bed and arrangements were made for him to come and pick it up from her residence. Nurse #1 also reported she knew nothing about a trailer with items in it. Nurse #1 reported that she had received training and was aware that she should not accept gifts from residents. On 2/17/26 at 9:18 AM an interview was conducted with Resident #19 who stated he did tell Nurse #1 she could have the truck bed but could not recall the exact date. Resident #19 reported he did not realize at the time the truck bed was scheduled to go to auction and be sold. Resident #19 reported he told Nurse #1 the next day, she could not have it because it was already promised for auction. Resident #19 reported that Nurse #1 obtained the truck bed after he told her she could no longer have it. Resident #19's Friend was interviewed by phone on 2/17/26 at 11:00 AM and stated he found out Nurse #1 was talking to Resident #19 about a car and a truck bed she could have. The Friend reported when Nurse #1 went to look at the car she also saw a trailer full of stuff she took. The interview further revealed that once the items were noticed missing, the Friend spoke to Resident #19 about missing items and was told that Resident #19 had given Nurse #1 permission to have the truck bed not realizing it was up for auction. The Friend explained he handled all affairs for Resident #19, and it was not okay for her to take those items. The Friend reported he contacted the police but ended up not pressing charges because he got the items back. The Friend reported that Nurse #1 went to Resident #19's house initially alone to look at buying a car. The Friend reported that the Nurse later had someone come and pick up the truck bed for her. The Friend reported he was not present when any of the items were looked at or picked up. Attempt was made to contact Adult Protective Services by phone for interview. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Voice mail message left requesting a return call were not returned. Local Law Enforcement was interviewed by phone on 2/23/26 at 8:53 AM. Officer stated local law enforcement was contacted because items were taken from Resident #19's property. The Officer reported it was a 2002 Ford truck bed and other miscellaneous property. The Officer reported allegedly, Resident #19 initially told Nurse #1 she could have the truck bed and other miscellaneous items. The Officer stated later Resident #19 found out from his Friend the items could not be given away because they were up for auction. The Officer indicated it was unclear if Nurse #1 took the items before or after finding out she could not have them. The Officer stated the items were eventually returned and no charges were pressed. DON #2 was interviewed by phone on 2/17/26 at 10:06 AM. She stated Resident #19 did report he gave Nurse #1 permission to have some of his items but reported he was unaware his belongings were involved in probate. DON #2 reported there were other items on a trailer mentioned but she does not recall the details of what they were. DON #2 reported Resident #19's Friend made the facility aware there was a problem because of the probate situation. DON #2 reported Nurse #1 was suspended while an investigation was conducted, education was also provided, and then Nurse #1 was permitted to return to work once the facility had completed the investigation. DON #2 reported the situation was resolved by having the items returned and the investigation was concluded as unsubstantiated. DON #2 reported no other residents were involved and there were no other concerns regarding Nurse #1 accepting items from other residents. The Administrator was interviewed on 2/17/26 at 11:39 AM and stated allegedly Nurse #1 had received permission to have some of the items Resident #19 offered her. The Administrator reported later, Resident #19's Friend who handles his affairs, came to the facility and reported Nurse #1 could not have those items that were taken because the items were already scheduled to go to auction. The Administrator reported Nurse #1 was made aware the items needed to be returned. The Administrator reported the Friend did not press charges and referred to it as a misunderstanding. The Administrator reported disciplinary corrective action was provided including not accepting gifts from residents per policy. The Administrator reported this education was provided to Nurse #1 initially when she was hired and again after the incident. The Administrator reported Nurse #1 was still employed at the facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, Medical Wound Provider and staff interviews, the facility failed to assess a newly identified pressure ulcer that included the pressure ulcer stage, characteristics, and presence of pain and failed to complete pressure ulcer treatments as ordered 3 out of 5 days. This was for 1 of 5 (Resident #2) residents reviewed for pressure ulcer care.The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses that included recent left above the knee amputation and history of a stroke. An admission progress note dated 12/3/25, completed by Nurse #9, indicated Resident #2 had a surgical wound to the left thigh with 35 staples present. Her right foot was dry and cracked. Discoloration and scarring were present to the right leg, bruising was present to the right ankle, and her buttocks were free from any skin breakdown. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 had moderately impaired cognition. She required maximum assistance with bed mobility and was dependent on staff for toileting hygiene and transfers. There was no pressure ulcers noted on the MDS but Resident #2 was coded for a surgical wound. A nursing note dated 12/27/25, written by Nurse #7, indicated Resident #2 was noted with a sacral wound, orders were received for wound care and Resident #2 would be seen by wound physician. The nurses' note read that wound care had been completed as ordered. There was no description of the sacral wound. A review of Resident #2's physician orders included an order dated 12/27/25 to cleanse wound to the sacral area with wound cleanser. Apply calcium alginate (a highly absorbent material used to create a moist healing environment) to the wound bed and cover with a dry dressing daily and as needed if soiled or dislodged. This order was discontinued on 12/31/25. A review of the December 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not contain the order for wound care to the sacral area dated 12/27/25. There was no documentation in the medical record that wound care had been provided to Resident #2's sacral wound on 12/28/25, 12/29/25 or 12/30/25. A phone interview was conducted with Nurse #7 on 2/18/26 at 11:37 AM. She stated that she began employment at the facility in the middle part of December 2025 as an as needed nurse (PRN) and recalled Resident #2 being found with skin breakdown to the sacral area. She was unable to recall which side of the sacrum the breakdown was noted on or how the area looked on 12/27/25. Nurse #7 stated that she contacted the Medical Wound Provider for wound orders and provided the care on that day. She stated she entered the wound care order into the Electronic Medical Record (EMR) system and that there was a box to activate the order onto either the MAR or TAR. She couldn't recall if that had been done but if the order didn't show up on the December 2025 MAR or TAR that would be why. Nurse #7 stated that she couldn't recall measuring the wound and felt the Medical Wound Provider would have done that when he assessed Resident #2. She stated that she only documented the new skin breakdown in the nursing note and thought she had reported it to the oncoming nurse, who she could not recall. Nurse #7 added that she didn't think there was a wound nurse at that time and that she had not been assigned to Resident #2 since 12/27/25. An interview occurred with Nurse #3 on 2/17/26 at 9:50 AM who was able to recall Resident #2. She recalled when Resident #2 was admitted to the facility on [DATE] she presented with a very thin area of pink and white tissue to her buttocks with the appearance of previously healed wounds. Nurse #3 stated when she completed skin assessments for Resident #2 on 12/6/25 and 12/21/25 the thin pink and white tissue area to her buttocks remained without any openings. Staff were providing protective skin care after each incontinent episode. Nurse #3 explained that when an order was placed in the EMR system it must be activated to show up on the MAR or TAR so staff would follow the order. An observation of wound care for Resident #2 was completed with the Wound Care Nurse on 2/17/26 at 10:13 AM. A (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	very small area of pink and white scar tissue was present to the right buttock, with no open areas. The left buttock contained a very small, irregular shaped open area that had no depth and pink/red wound bed. There was no drainage or odor. Wound care was completed as ordered. On 2/17/26 at 4:07 PM, an interview occurred with the wound care nurse. She stated that she had worked at the facility since October 2025 as a floor nurse and had recently transitioned to the wound care nurse position in January 2026. She recalled being assigned to care for Resident #2 in December 2025 and that Resident #2 had a very thin area of pink and white tissue to the sacral area when she was first admitted to the facility. The wound care nurse had been assigned to Resident #2 on 12/29/25 and 12/30/25. She stated at that time the floor nurses were completing wound care, but she couldn't recall if she had provided any wound care to Resident #2 on 12/29/25 or 12/30/25 or if she was aware Resident #2 had skin breakdown to her sacrum as she was not the wound care nurse during this time. She added that during the end of December 2025 the Medical Wound Provider was responsible for measuring the wounds and assessing them for proper treatment, as there was not a wound care nurse. The wound care nurse reviewed the initial order for sacral wound care that was entered in the physician orders on 12/27/25 and explained that if the initial order was not activated to show up on the MAR or TAR, nursing staff would not have known to complete the wound care. She further explained that in the role of wound care nurse, she was made aware of any new skin concerns by the floor nurses and followed up to ensure the wound care orders had been entered appropriately and the resident was assessed by the Medical Wound Provider. She indicated that she provided wound care to all residents Monday through Friday and that floor nurses were responsible for any wound care that was needed after 5:00 PM and on the weekends. A phone interview was completed with the Medical Wound Provider on 2/18/26 at 10:11 AM. The Medical Wound Provider could not recall any concerns of a dressing not being present to Resident #2's pressure area on the initial visit of 12/31/25 and stated he would have noted any concerns he had on the progress note. The initial order provided on 12/27/25 was reviewed with the Medical Wound Provider and stated that he recalled providing that order until he could see Resident #2 in the next few days. He couldn't comment if not having the wound care affected the outcome of the wound but replied there were no concerns for infection. The Medical Wound Provider added that it was evident there was scar tissue in the area of her pressure injuries when he assessed her on 12/31/25 and that due to Resident #2's co-morbidities and overall change from the recent amputation, it was possible the wounds erupted very quickly. The Director of Nursing (DON) was interviewed on 2/18/26 at 2:42 PM and stated that she had recently taken over the role earlier in February 2026 and was unaware that the wound care orders dated 12/27/25, had not been populated to the December 2025 MAR or TAR for Resident #2. The DON stated that in the first part of January 2026, the facility designated a nurse for wound care. The process since January 2026 was when a skin problem was identified, the nurse was made aware. They called the provider for wound care orders, entered them into the EMR system so that it populated to the TAR and sent a communication to the wound care nurse. The wound care nurse ensured that the wound care orders had been transcribed and activated properly in the EMR. The DON added that she would expect wound care to be completed as ordered, as well as expecting Nurse #7 to have documented a description of the wound in the nursing progress note. She was unsure if the prior DON #3 had been made aware. Multiple attempts were made to contact Nurse #5, who was scheduled to care for Resident #2 on 12/27/25 from 7:00 PM to 7:00 AM. These attempts were made on 2/17/26 at 5:45 PM and 2/18/26 at 11:19 AM. Multiple attempts were made to contact the prior DON #3 on 2/17/26 at 5:00 PM and 2/18/26 at 11:17 AM regarding the process for newly identified wounds in December 2025.