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	05/21/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff, Pharmacy Consultant, and Medical Director interviews, the facility failed to administer scheduled medications as ordered by the physician for 6 of 32 residents on the D and E halls that were reviewed for medication administration (Residents #4, #5, #6, #7, #8 and #9).The findings included: A. Resident #4 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease with dyskinesia (a movement disorder defined by involuntary and uncontrollable muscle movements). Review of the active physician orders included the following orders:- An order dated 1/15/25 for ropinirole (a medication used to improve muscle control and manage movement) 0.25 milligrams (mg). Give one tablet by mouth three times a day for Parkinson's disease.- An order dated 1/16/25 for Benztropine Mesylate (a medication used to reduce muscle stiffness, body spasms and tremors) 0.5 mg. Give one tablet by mouth in the afternoon for dyskinesia.- An order dated 1/6/25 for Sinemet (a medication used to treat Parkinson's disease) 25-100 mg. Give one tablet by mouth four times a day for Parkinson's disease. Review of the May 2026 Medication Administration Record (MAR) indicated Resident #4 did not receive ropinirole 0.25 mg at 1:00 PM, Benztropine Mesylate 0.5 mg at 1:00 PM or Sinemet 25-100 mg at 2:00 PM on 5/16/26. B. Resident #5 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and hypertension. Review of the active physician orders revealed an order dated 12/16/25 for hydralazine (a medication used to treat high blood pressure) 10 mg. Give one tablet by mouth three times a day for essential hypertension. Hold for systolic blood pressure (the top number of the blood pressure reading) less than 110. Review of the May 2026 MAR indicated that Resident #5 did not receive hydralazine 10 mg at 2:00 PM on 5/16/26. C. Resident #6 was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder. A review of the active physician orders included the following orders:- An order dated 4/3/26 for buspirone (a medication used to treat chronic anxiety) 15 mg. Give one tablet by mouth three times a day for anxiety.- An order dated 5/16/26 for depakote sprinkles (a medication used as a mood stabilizer) 125 mg. Give two capsules by mouth in the afternoon for bipolar disorder. Review of the May 2026 MAR revealed Resident #6 did not receive buspirone 15 mg or depakote sprinkles 125 mg at 2:00 PM on 5/16/26. D. Resident #7 was admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis and polyneuropathy. A review of the active physician orders included an order dated 12/10/25 for Acetaminophen (a medication used to treat mild-to-moderate pain) 650 mg by mouth three times a day for acute and chronic pain/back pain. The May 2026 MAR was reviewed and revealed Resident #7 did not receive Acetaminophen 650 mg at 1:00 PM as ordered on 5/16/26. E. Resident #8 was admitted to the facility on [DATE] and had diagnoses that included primary open-angle glaucoma of the right eye, other corneal scars and blindness to the right eye. A review of the active physician orders included an order dated 9/5/24 for dorzolamide (a medication used to lower high pressure inside the eye) ophthalmic solution 2%. Instill one drop in both eyes every 8 hours for glaucoma. The May 2026 MAR was reviewed and indicated that Resident #8 did not receive dorzolamide eye drops as scheduled at 2:00 PM on 5/16/26. F. Resident #9 was admitted to the facility on [DATE] with diagnoses that included fibromyalgia, bilateral primary osteoarthritis of the knee and polyneuropathy. The active physician orders included an order dated 11/18/25 for (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Acetaminophen (a medication used to treat mild-to-moderate pain) 325 mg. Give two tablets by mouth three times a day for chronic pain. A review of the May 2026 MAR indicated that Resident #9 did not receive Acetaminophen at 1:00 PM on 5/16/26. An interview occurred with Nurse #1 on 5/20/26 at 2:55 PM, who indicated that she had worked from 7:00 AM to 7:00 PM on 5/16/26. She stated after 12:45 PM, there were only two nurses (Nurse #2 and herself) in the facility to administer medications due to Medication Aide (MA #1), who was assigned to D and E halls, leaving. Nurse #1 stated there was no effort from MA #1 to provide report or hand off the assignment when she left at 12:45 PM, and additionally she felt uncomfortable being responsible for an additional assignment. Nurse #1 stated she texted the Administrator and interim Director of Nursing (DON) in a group text regarding the staffing situation that morning and again at 12:45 PM, when MA #1 left and was told by the Administrator that they were working on finding a replacement and that medications were caught up till 5:00 PM. Nurse #1 stated that she did not administer any medications to the D and E hall residents from 1:00 PM to 5:00 PM. Nurse #1 indicated that Unit Manager #1 arrived at the facility shortly after 5:00 PM as the replacement for MA #1. Nurse #2 was interviewed on 5/20/26 at 3:08 PM and stated that she worked from 7:00 AM to 7:00 PM on 5/16/26. She stated that MA #1 left around 12:45 PM, leaving only two nurses in the facility to administer medications (Nurse #1 and herself). She recalled MA #1 stated she was only working four hours and made no effort to hand off the assignment when she left at 12:45 PM, for the D and E hall residents. Nurse #2 added that she was uncomfortable being responsible for an additional assignment. Nurse #2 stated that she was aware Nurse #1 had been texting with the Administrator and interim DON regarding the staffing issue and was advised they were working on a replacement for MA #1. Nurse #2 stated that she did not administer any medications to the D and E hall residents from 1:00 PM to 5:00 PM. Nurse #2 stated that Unit Manager #1 was present at the facility at 5:00 PM as a replacement for MA #1. MA #1 was interviewed on 5/20/26 at 3:20 PM and explained that her primary job duty was as medical records during the week, but she assisted as a MA when needed. She stated that on 5/16/26 she was the manager on duty for four hours and arrived at the facility at 7:30 AM. She was contacted by the staffing scheduler close to 8:00 AM and was asked if she could cover the medication cart for D and E halls. She agreed and verified there were two nurses in the facility at that time. MA #1 stated that she left at 12:45 PM saying, All knew that I was working four hours since I was the manager on duty. MA #1 stated that at 12:45 PM, she told the two nurses her time was up and left. MA #1 stated she reached out to the Staffing Scheduler and the Administrator and was told they were working on finding a replacement. MA #1 stated that no one would take her assignment from her. MA #1 further stated that she provided the morning and any lunch time medications that were ordered for residents on the D and E halls on 5/16/26. MA #1 stated that if a medication was not signed out as given at 1:00 PM or 2:00 PM for any resident on D or E hallway, then she didn't provide it to them on 5/16/26. On 5/20/26 at 3:29 PM, an interview was conducted with Unit Manager #1, who recalled she had been called by the Administrator in the afternoon of 5/16/26 and asked if she could cover a medication cart. She let him know that she could be there at 5:00 PM and worked the D and E hall medication cart on 5/16/26 from 5:00 PM to 7:00 PM. An interview occurred with the Staffing Scheduler on 5/20/26 at 3:36 PM, who explained that MA #1 was the manager on duty on 5/16/26, knew she would be at the facility, and asked her if she could cover the D and E hall medication cart that morning. The Staffing Scheduler indicated MA #1 was not prepared to stay for a full shift. She indicated that both the interim DON and Administrator were aware and that attempts to find a replacement for MA #1 were made. The Staffing Scheduler verified Unit Manager #1 was able to come in the facility at 5:00 PM on 5/16/26 and between 1:00 PM and 5:00 PM two nurses were in the facility. A phone interview was conducted with the Pharmacy Consultant on 5/21/26 at 11:35 AM and reviewed medications that were missed on 5/16/26 for Residents #4, #5, #6, #7, #8 and #9. He stated that none of the medications that were not provided on 5/16/26 were considered significant. The Medical Director was interviewed via phone on 5/21/26 at 4:30 PM and reviewed #4, #5, #6, #7, #8 and #9's medications that were not provided on 5/16/26. She (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that she did not consider any of the medications not provided as significant as most of them were provided at other times during the day or the next day. She added that missing a single dose of medication in many chronic conditions would not have resulted in adverse outcomes. A phone interview was completed with the interim DON on 5/21/26 at 12:39 PM, who explained she started at the facility on 5/14/26. The interim DON stated that MA #1 should have taken every opportunity to hand off her assignment on 5/16/26 before leaving the facility at 12:45 PM or have reached out to her (interim DON) if there was an issue. The interim DON added that she was unaware there were issues with nurse staffing on 5/16/26 or she would have come into the facility and taken the assignment for the D and E hall medication cart until a replacement could be secured. A phone interview occurred with the Administrator on 5/21/26 at 12:55 PM and stated that he initiated asking MA #1 to assist with the D and E hall medication cart on 5/16/26 as he knew she would be at the facility as the manager on duty and was aware that she could only work for approximately four hours. The Administrator stated that both he and the Staffing Scheduler were calling staff for a replacement for MA #1 and that he was aware there would be a medication pass in the evening around 5:00 PM. The Administrator indicated he was trying to recruit someone to come in for that afternoon medication pass and wasn't aware there were residents with medications ordered between 1:00 PM and 5:00 PM. The Administrator added that he thought the two nurses on duty 5/16/26 from 7:00 AM to 7:00 PM would've covered the medication cart for any needed medications until the replacement arrived and was not aware that some of the resident's on the D and E halls did not receive their medications as ordered.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, Pharmacy Consultant, Medical Director and staff interviews, the facility failed to ensure there was sufficient nursing staff in the facility on 5/16/26 from 1:00 PM to 5:00 PM to administer medications as ordered to the D and E halls for 6 of 32 residents reviewed for medication administration (Resident's #4, #5, #6, #7, #8 and #9).The findings included: This tag is cross referenced to: F658: Based on record reviews, Pharmacy Consultant, Medical Director and staff interviews, the facility failed to administer scheduled medications as ordered by the physician for 6 of 32 residents on the D and E halls that were reviewed for medication administration. (Residents ##4, #5, #6, #7, #8 and #9). The facility's daily assignment sheet dated 5/16/26 revealed the following nursing staff were scheduled to work during the day shift (7:00 AM to 7:00 PM) for medication administration. Nurse #1 was assigned to work on the A and F halls from 7:00 AM to 7:00 PM), Nurse #2 was assigned to work on the B and C halls from 7:00 AM to 7:00 PM, Medication Aide (MA) #1 was assigned to work on the D and E halls from an unknown time and Unit Manager #1 was assigned to work on the D and E halls from an unknown time. The daily nurse staff posted report dated 5/16/26 indicated the resident census was 65. A review of the payroll time reports for 5/16/26 were reviewed and revealed MA #1 clocked in for the shift on 5/16/26 at 7:29 AM and clocked out for the day at 12:54 PM. Unit Manager #1 clocked in for the shift on 5/16/26 at 5:10 PM and clocked out at 7:35 PM.