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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observation and staff interviews, the facility failed to discard expired medications and date open multiple-dose medications in 2 of 3 medication carts (A and D medication carts) and 1 of 1 medication storage room observed.Findings included: a. On 2/15/26 at 12:35PM, the medication room was observed with the Director of Nursing (DON) and Nurse #2. There was one open undated vial of Apilsol Tuberculin Purified Protein Derivative (PPD) solution stored in the refrigerator (The manufacturer's storage instruction indicated once opened the solution should be discarded within 30 days). b. On 2/15/26 at 2:38 PM, the medication cart for hall A was observed with Nurse #4. The following expired and undated medications were observed in the cart:- One bottle of Nitroglycerin 0.4 milligram (mg) tablet - expiration date 1/2026,- Two Humalog Insulin KwikPens opened and undated (The manufacturer's Insulin storage instruction indicated once opened, Humalog should be stored at room temperature and used within 28 days),- One Insulin Glargine Injection Pen opened and undated (The manufacturer's Insulin storage instruction indicated once opened, Insulin Glargine should be stored at room temperature and used within 28 days),- One Humalog Insulin KwikPen opened with date opened 1/7/26 (The manufacturer's Insulin storage instruction indicated once opened, Insulin should be stored at room temperature and used within 28 days),- One Basagler Insulin KwikPen opened and undated (The manufacturer's Insulin storage instruction indicated once opened, Basagler should be stored at room temperature and used within 28 days),- One Insulin Glargine Injection Pen opened with dated opened 1/7/26 (The manufacturer's Insulin storage instruction indicated once opened, Insulin Glargine should be stored at room temperature and used within 28 days).On 2/15/26 at 3:32 PM, Nurse #4 stated the nurse who opened a medication was responsible for writing the date opened on medications that required dating. She stated night nurses were expected to routinely check medication carts and the medication room and remove expired medications found; however, she indicated overall monitoring of medications was a group effort. Nurse #4 stated she usually looked through the medications on her medication cart but had not had a chance yet today.c. On 2/15/26 at 2: 58PM, the medication cart for hall D was observed with Nurse #6. The following expired and undated medications were observed in the cart:- One Novolin R FlexPen used and undated (The manufacturer's Insulin storage instruction indicated once opened, Novolin R should be stored at room temperature and used within 28 days),- One bottle of 200mg Ibuprofen tablets - expiration date 12/2025.On 2/15/26 at 3:36 PM, Nurse #6 stated monitoring medication carts and medication storage rooms for unlabeled and expired medications was a team effort. She indicated she attempted to check her cart daily but had not checked it yet. She confirmed that the nurse who opened a medication was responsible for dating it and removing any expired medications.An interview was conducted on 2/18/22 at 4:13 PM with the DON revealed night shift nurses were responsible for checking medication carts and the medication storage room nightly for expired medications. The DON further stated the Nurse who opened a medication was responsible for dating it if the medication required dating. She indicated it was her expectation that nurses date medications upon opening and discard expired medications as needed.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to label and date food items and maintain food in sealed containers in the kitchen. Specifically, the facility did not label and date cups of orange juice in 1 of 1 walk-in cooler; did not seal and label a box of frozen biscuits with the date opened in 1 of 1 walk-in freezer; did not keep a small container of pimento cheese sealed in 1 of 1 reach-in refrigerator; and seal and label a box of rice with the date opened in the dry storage area. These practices had the potential to affect the safety and quality of food served to residents. The findings included:1. An observation on 2/15/26 at 10:05 AM revealed the following in the reach-in refrigerator: One small metal container of pimento cheese was loosely covered with plastic wrap, leaving it exposed to air. The date written on the wrap was obscured.The [NAME] was interviewed during the initial observation on 2/15/26 at 10:05 AM. She stated the pimento cheese was made the morning of 2/15/26. The cook did not respond when asked about the pimento cheese not being sealed. She was observed removing the pimento cheese from the reach-in refrigerator. She replaced the plastic wrap, wrote a date in permanent marker on the plastic wrap, and attempted to place the container back in the reach-in refrigerator. She was made aware the pimento cheese was not safe to serve because it was unknown how long it had been unsealed.2. An observation on 2/15/26 at 10:15 AM revealed the following in the dry storage area: One 25-pound box of white rice was stored in an unsealed bag open to air and not marked with the date opened.The [NAME] was interviewed during the initial observation on 2/15/26 at 10:15 AM. The [NAME] stated she did not know why the box was open to air and not marked with the date opened.3. An observation on 2/15/26 at 10:25 AM revealed the following in the walk-in cooler: Seven 4-ounce cups of orange juice covered with plastic wrap but unlabeled and undated.The [NAME] was interviewed during the initial observation on 2/15/26 at 10:25 AM. She stated night shift staff prepared orange juice each night and were responsible for labeling and dating it.4. An observation on 2/15/26 at 10:40 AM revealed the following in the walk-in freezer: One box of frozen biscuits was stored in an unsealed bag open to air and not marked with the date opened.The [NAME] was interviewed during the initial observation on 2/15/26 at 10:40 AM. The [NAME] stated she did not know why the box was open to air and not marked with the date opened.On 2/15/26, the Dietary Manager and District Dietary Manager confirmed that all food items should be labeled and dated when prepared, opened, or stored after opening. They stated staff were aware of this requirement and did not understand why it was not followed. They confirmed night shift staff should have labeled and dated the orange juice. A follow-up walkthrough revealed all unlabeled, undated, and unsealed food items had been discarded.On 2/18/26 at 4:27 PM, the Director of Nursing (DON) and Administrator stated they were unaware of the failure to label and date food items. Both acknowledged the requirement and discussed that staff could have used a permanent marker when tape was unavailable. The Administrator stated a better system for labeling and dating food items needed to be implemented. Both reiterated their expectation that kitchen staff follow established protocols.

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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 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. 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of accidents (Resident #11), and medications (Residents #49 and #21). This was for 3 of 24 residents whose MDS assessments were reviewed. The findings included: 1. Resident #11 was originally admitted to the facility on [DATE] with diagnoses that included history of a stroke and muscle weakness. A review of Resident #11's medical record revealed he had a fall on 12/13/25 with a minor injury of a skin tear to his right arm. The quarterly MDS assessment dated [DATE] indicated Resident #11 had severely impaired cognition. He was coded with one fall with no injury since the previous assessment. On 2/17/26 at 3:03 PM, an interview occurred with the MDS Consultant who had coded the 12/17/25 quarterly MDS assessment. She reviewed the MDS assessment dated [DATE] as well as Resident #11's medical record and confirmed Resident #11 had a fall on 12/13/25 that resulted in a skin tear to his right arm. She indicated that the fall section should have been coded as one fall with a minor injury instead of one fall with no injury and felt it was an oversight. An interview was conducted with the Director of Nursing (DON) on 2/18/26 at 2:42 PM, who stated that it was her expectation for the MDS assessments to be coded accurately for accidents. 2. Resident #49 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder and age-related cataracts. A review of Resident #49's Medication Administration Record (MAR) from 1/16/26 to 1/22/26 revealed he received the following antibiotics: Macrobid 100 milligrams (mg) by mouth once a day. Moxifloxacin 0.5% solution one drop to the left eye every two hours for post cataract removal. The quarterly MDS assessment dated [DATE] revealed Resident #49 was not coded for antibiotic use. On 2/17/26 at 3:03 PM, an interview occurred with the MDS Consultant. She reviewed the January 2026 MAR and confirmed that antibiotic use should have been coded on the quarterly MDS dated [DATE]. The MDS Consultant stated that someone had been assisting remotely to complete this MDS assessment and felt it was an oversight. During an interview on 2/18/26 at 2:42 PM, the DON indicated it was her expectation for the MDS to be coded correctly for antibiotic use 3. Resident #21 was admitted to the facility on [DATE] with diagnosis that included bipolar I disorder, current manic with psychotic features and Schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's January 2026 active physician orders revealed an order dated 01/24/26 for Fluphenazine Decanoate Injection Solution 25 milligram (MG)/milliliter (ML), inject 50 mg intramuscularly one time a day every 21 day(s) for bipolar disorder (antipsychotic intramuscular injection). There was also an order dated 01/23/26 for Lamotrigine oral tablet 25 MG, give 2 tablets by mouth two times a day for Extrapyramidal Symptoms (EPS) (involuntary movements such as tremors, rigidity, and restlessness) (anticonvulsant medication). Review of the January 2026 medication administration record (MAR) revealed Fluphenazine Decanoate injection was administered on 01/24/26 at 9:00 AM and Lamotrigine oral tablet was administered daily from 01/24/26 through 01/31/26 at 9:00 AM and 5:00 PM. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #21's cognition was intact. The medication section was coded for receiving 0 out of 7 injections of any type during the lookback period. The medication section was not coded for receiving an anticonvulsant medication during the lookback period. An interview was conducted on 02/16/26 at 3:26 PM with the Corporate MDS Consultant. She reviewed the admission MDS assessment dated [DATE] along with the January medication administration record (MAR). The Corporate MDS Consultant verified she did not accurately code the admission assessment and stated she overlooked the intramuscular part of the antipsychotic medication order. She explained that she was thinking about antipsychotic medications and not anticonvulsants when she was reviewing the MAR and overlooked the anticonvulsant medication. She indicated she expected the MDS assessments to be coded accurately to reflect Resident #21's medications and needs. An interview was completed on 02/18/26 at 1:32 PM with the Administrator. He stated the MDS should be coded accurately to reflect Resident #21's physical, cognitive, emotional and behavioral conditions, and care needs.

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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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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	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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with staff and Medical Director, the facility failed to provide behavioral healthcare services to a resident with diagnosed mental health disorders and behavioral symptoms for 1 of 1 resident (Resident #21) reviewed for behavioral and emotional needs.The findings included:A review of Resident #21's hospital Discharge summary dated [DATE] revealed he was admitted on [DATE] and discharged on 01/23/26 with discharge diagnosis that included bipolar I disorder-manic. His hospital course included psychiatry was consulted for Extrapyramidal Symptoms (EPS) (involuntary movements such as tremors, rigidity, and restlessness) agitation, and acute mania. Resident #21's discharge summary also included the following:Follow up appointments: Please make sure to follow up with Psychiatric appointments and medication management. Resident #21 was admitted to the facility on [DATE] with diagnosis that included 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.Resident #21's active physician's orders included the following psychotropic medications:- 01/23/26: olanzapine (Zyprexa) Oral Tablet 10 milligram (MG), give 1 tablet by mouth at bedtime for bipolar disorder (atypical antipsychotic medication used to treat schizophrenia and bipolar I disorder). - 01/23/26: Lamotrigine Oral Tablet 25 MG, give 2 tablet by mouth two times a day for Extrapyramidal Symptoms (EPS) (involuntary movements such as tremors, rigidity, and restlessness) (anticonvulsant medication), used to treat bipolar disorder by stabilizing mood. - 01/24/26: Fluphenazine Decanoate Injection Solution 25 milligram (MG)/milliliter (ML), inject 50 mg intramuscularly one time a day every 21 day(s) for bipolar disorder (antipsychotic intramuscular injection used for the long-term management of schizophrenia).An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #21's cognition was intact and there were no behaviors coded during the lookback period. Resident #21 was coded for receiving antipsychotic medications. The identification information section was coded as Resident #21 having a level II Pre-admission Screening and Resident Review (PASRR). A review of Resident #21's behavioral documentation located on the medication administration (MAR) from 01/23/26 through 02/13/26 revealed the following:- calling out: 01/28/26, 01/29/26, 01/30/26, and 02/03/26, -screaming and calling out: 01/23/26, 01/26/26, 01/31/26, 02/01/26, 02/04/26, 02/05/26, 02/09/26, 02/10/26, and 02/13/26. A review of Resident #21's medical record from 01/23/26 through 02/16/26 revealed no psychiatric services or other behavioral health care services were provided to the resident.A continuous observation was completed on 02/16/26 from approximately 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).An interview was conducted on 02/16/26 at 11:31 AM with Med Aide (MA) #2. Resident #21 was yelling and screaming for assistance and MA #2 stated oh he does that, he yells out for assistance. She further stated she did not know how long Resident #21 had been yelling this time.An interview was conducted on 02/17/26 at 10:00 AM with Nurse #3. She stated that Resident #21 does yell out for assistance, but he didn't utilize his call bell. She verified she was the admitting nurse for Resident #21 however she did not recall seeing the referral for psychiatry services. She explained that when a resident was admitted to the facility the admitting nurse reviewed the hospital discharge summary for several things including follow-up appointments. If there was a referral or follow-up appointment related to psychiatric services or if the resident was on any psychotropic medications a copy of the referral was put in the social workers box for further follow through. She went on to explain that the psychiatry providers came into the building 2-3 times a week. Nurse #3 then stated she did not know how or why Resident #21 had not been seen by psychiatry yet due to his behaviors. Nurse #3 went on to say she documented his (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors on the medication administration record. An interview was conducted on 02/17/26 at 10:25 AM with the Social Services Director. She verified she had not received a referral order for a psychological consultation for Resident #21. She explained that each month she received a list from the psychiatric provider of all residents who were active indicating they were receiving services, Resident #21 was not on that list. She indicated the psych consent had not been completed as of right now for Resident #21. She explained that if a resident was admitted to the facility with psychotropic medications, a mental health diagnosis, or a referral from the hospital that the admitting nurse would put the information in her mailbox and she would arrange for a consultation. Psych comes in every 2 weeks, and psych talk comes in weekly. Psych would pick them up on the next visit after the referral had been sent to themAn interview was conducted on 02/18/26 at 12:01 PM with the Medical Director. She indicated that it was her expectation for facility residents to receive the care and services necessary to meet their behavioral healthcare needs. An interview was conducted on 02/18/26 at 4:02 PM with the Director of Nursing (DON). She indicated she expected residents to receive the care and services necessary to meet their behavioral healthcare needs. The DON revealed she was unaware Resident #21 had not been referred to or was not being seen by the psychiatric provider.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Medical Director and staff interviews, the facility failed to hold a blood pressure medication as ordered by the physician for 1 of 6 residents whose medications were reviewed (Resident #49) for unnecessary medication.The findings included: Resident #49 was admitted to the facility on [DATE] with diagnoses that included hypertension and heart failure. Review of Resident #49's physician orders included an order dated 9/6/24 for Metoprolol Tartrate (a medication for high blood pressure) 25 milligrams (mg). Give 12.5 mg by mouth every 12 hours. Hold if systolic blood pressure (SBP-the top number in the blood pressure reading) is less than 110. The January 2026 Medication Administration Record (MAR) was reviewed and revealed Resident #49 had received Metoprolol Tartrate, despite the SBP being below 110 on the following dates:1/3/26 for 9:00 PM dose, SBP was 109 administered by Nurse #5.1/9/26 for 9:00 PM dose, SBP was 109 administered by Medication Aide (MA) #1.1/10/26 for 9:00 PM dose, SBP was 99 administered by MA #1.1/12/26 for 9:00 PM dose, SBP was 106 administered by MA #1. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #49 was cognitively intact. On 2/18/26 at 3:30 PM, an interview was conducted with MA #1, who reviewed the January 2026 MAR and verified the Metoprolol Tartrate was administered despite the SBP being below 110 when it should have been held for the 9:00 PM dose on 1/9/26, 1/10/26 and 1/12/26. She stated it was an oversight. Attempts to contact Nurse #5 were made without success on 2/17/26 at 5:45 PM and 2/18/26 at 11:19 AM. The Medical Director was interviewed on 2/18/26 at 12:01 PM and didn't feel Resident #49 would have suffered any serious harm by receiving Metoprolol Tartrate outside the parameter, however, she would expect the nursing staff to follow the orders for the Metoprolol Tartrate blood pressure parameter as written. An interview occurred with the Director of Nursing (DON) on 2/18/26 at 2:42 PM and stated she expected the nursing staff to follow physician orders including blood pressure medications with parameters to hold. The DON explained that she had recently taken over the role earlier in February 2026 and was unaware that the staff had administered the medication outside of the prescribed parameters.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, record review, and staff interviews, the facility failed to post the most recent survey of the facility in the survey results notebook. This occurred for 2 of 4 days of the survey (2/15/26 and 2/17/26).Findings included: According to the iQIES database system, the facility's most recent survey was a complaint investigation survey completed on 11/7/25. During tours of the facility on 2/15/26 at 9:45 AM and 2/17/26 at 9:00 AM, the facility's survey results were observed in a notebook placed on a low table in the front lobby. The notebook contained survey results from a recertification survey completed on 8/16/23. The following surveys were not included in the survey results notebook:A compliant investigation survey dated 1/30/24.A focused infection control survey dated 4/8/24.A complaint investigation survey dated 8/22/24.A recertification survey dated 11/21/24.A complaint investigation survey dated 12/30/24.A complaint investigation survey dated 1/15/25.A complaint investigation survey dated 7/15/25.A complaint investigation survey dated 11/7/25. In an interview on 2/17/26 at 9:38 AM, the Administrator indicated he began employment at the facility at the end of July 2025. He stated that technical issues prevented him from printing the survey results when he first arrived at the facility. He indicated that he had the survey results in his office but had not placed them in the binder. The Administrator acknowledged that he should have placed the survey results in the notebook as soon as he was able to print them but was unable to state why this had not been done. The Administrator stated he was aware of the regulation regarding the most recent survey results from any survey should be placed in the notebook.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff scheduled for licensed and unlicensed nursing staff for 22 out of 46 days (1/6/26, 1/7/26, 1/10/26, 1/13/26, 1/14/26, 1/15/26, 1/16/26, 1/17/26, 1/18/26, 1/19/26, 1/20/26, 1/21/26, 1/22/26, 1/23/26, 1/24/26, 1/25/26, 1/28/26, 1/30/26, 1/31/26, 2/1/26, 2/2/26, and 2/3/26). The findings included: A review of the facility's daily posting for nursing staff for 1/1/26-2/15/26 as compared to the daily staffing schedule revealed an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 1/6/26 indicated that 6 Nurse Aides (NAs) worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 1/6/26 documented that 5 NAs worked 7:00 AM to 3:00 PM. b. The nursing schedule for 1/7/26 indicated that 6 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 1/7/26 documented that 7 NAs worked from 3:00 PM to 11:00 PM. c. The nursing schedule for 1/10/26 indicated that 2 Medication Aides (MAs) worked from 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/10/26 documented that 1 MA worked 7:00 PM to 7:00 AM. d. The nursing schedule for 1/13/26 indicated that 6 NAs worked from 7:00 AM to 3:00 PM and 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/13/26 documented that 7 NAs worked 7:00 AM to 3:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. e. The nursing schedule for 1/14/26 indicated that 1 MA worked from 7:00 AM to 7:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/14/26 documented that 2 MAs worked 7:00 AM to 7:00 PM and 7 NAs worked 11:00 PM to 7:00 AM. f. The nursing schedule for 1/15/26 indicated that 5 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/15/26 documented that 7 NAs worked 11:00 PM to 7:00 AM. g. The nursing schedule for 1/16/26 indicated that 1 Registered Nurse (RN) and 1 Licensed Practical Nurse (LPN) worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/16/26 documented that no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. h. The nursing schedule for 1/17/26 indicated that 1 RN, 1 MA and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/17/26 documented that no RN or MA worked from 7:00 PM to 7:00 AM and that 2 LPNs worked 7:00 PM to 7:00 AM. i. The nursing schedule for 1/18/26 indicated that 6 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 1/18/26 documented that 7 NAs worked 7:00 AM to 3:00 PM. j. The nursing schedule for 1/19/26 indicated that 5 NAs worked from 7:00 AM to 3:00 PM and 4 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/19/26 documented that 6 NAs worked 7:00 AM to 3:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. k. The nursing schedule for 1/20/26 indicated that 4 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/20/26 documented that 3 NAs worked from 11:00 PM to 7:00 AM. l. The nursing schedule for 1/21/26 indicated that 1 RN and 2 LPNs worked from 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/21/26 documented that no RN worked 7:00 PM to 7:00 AM and 3 LPNs worked 7:00 PM to 7:00 AM. m. The nursing schedule for 1/22/26 indicated that 1 RN and 2 LPNs worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/22/26 documented that 3 LPNs worked 7:00 PM to 7:00 AM. n. The nursing schedule for 1/23/26 indicated that 2 LPNs worked 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 1/23/26 documented that 1 LPN worked 7:00 AM to 7:00 PM. o. The nursing schedule for 1/24/26 indicated that 1 MA worked from 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 1/24/26 documented that no MA worked 7:00 AM to 7:00 PM. p. The nursing schedule for 1/25/26 indicated that 6 NAs worked from 7:00 AM to 3:00 PM and 3 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/25/26 documented that 4 NAs worked 7:00 AM to 3:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. q. The nursing schedule for 1/28/26 indicated that no MA worked 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 1/28/26 documented that 1 MA worked from 7:00 AM to 7:00 PM. r. The nursing schedule for 1/30/26 indicated that 2 MAs worked from 7:00 AM to 7:00 PM, 1 RN worked 7:00 PM to 7:00 AM and 1 LPN worked 7:00 (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	PM to 7:00 AM. The daily posted nurse staffing sheet for 1/30/26 documented that no MAs worked 7:00 AM to 7:00 PM, no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. s. The nursing schedule for 1/31/26 indicated that 1 MA worked from 7:00 AM to 7:00 PM, 1 RN worked 7:00 PM to 7:00 AM and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/31/26 documented that no MA worked 7:00 AM to 7:00 PM, no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. t. The nursing schedule for 2/1/26 indicated that 1 RN and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/1/26 documented that no RN worked from 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. u. The nursing schedule for 2/2/26 indicated that 1 RN and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/2/26 documented that no RN worked 7:00 PM to 7:00 AM and that 2 LPNs worked 7:00 PM to 7:00 AM. v. The nursing schedule for 2/3/26 indicated that 6 NAs worked 7:00 AM to 3:00 PM, 1 LPN worked 7:00 PM to 7:00 AM and 1 RN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/3/26 documented that 8 NAs worked 7:00 AM to 3:00 PM, no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. On 2/18/26 at 9:17 AM, an interview occurred with the Staff Scheduler. She reviewed the staffing schedule and daily postings and verified the number of staff who worked from 1/1/26 to 2/15/26 did not match. She explained that she had not counted Nurse #8 as an RN on the nursing schedule or daily posted nurse staffing sheet on 1/16/26, 1/17/26, 1/21/26, 1/22/26, 1/30/26, 1/31/26, 2/1/26, 2/2/26 and 2/3/26 because when Nurse #8 was first hired at the facility, he was an LPN waiting to take the test for his RN license. She stated she couldn't recall when he became an RN. In addition, the Staff Scheduler stated that she failed to ensure the daily posted nurse staffing sheet had been updated when a staff member didn't come to work or if a staff member came in to cover a need The Human Resources Coordinator was interviewed on 2/18/26 at 9:55 AM. She verified that Nurse #8's date of hire was 12/30/25 and that he became an RN effective 1/13/26. An interview occurred with the Administrator and Director of Nursing (DON) on 2/18/26 at 2:42 PM. The staffing schedules and daily postings were reviewed, which did not match the actual staff that worked on a certain day. The Administrator stated he recalled letting the Staffing Scheduler know of Nurse #8's transition from LPN to RN after he passed the RN boards in January 2026. In addition, the Administrator and DON stated that the daily staff schedule posting, and the staffing schedule should match the number of staff worked on any given shift.

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F 0698 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain evidence of ongoing communication with the dialysis treatment center in the medical record for 1 of 2 residents reviewed for dialysis (Resident #65). The findings included:Resident #65 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD) and dependence on dialysis (treatment to filter waste and water from the blood). Resident # 65 was discharged on 12/19/25.Resident #65 had a physician order dated 12/4/25 for hemodialysis on Tuesday, Thursday, and Saturday.A review of Resident #65's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 was cognitively intact. Resident #65 was not coded as receiving dialysis (not coded in error).A Review of Resident #65's electronic medical record revealed no completed dialysis communication forms. The facility was unable to locate any dialysis communication forms for Resident #65.A review of Resident #65 progress notes revealed there was no documentation of communication between the facility staff and dialysis center. There was no documentation that pre-dialysis or post-dialysis assessments were completed and communicated between the facility and the dialysis center.An interview completed with Nurse #4 on 2/17/26 at 12:16 PM revealed she was Resident #65's nurse regularly on her scheduled dialysis days. Nurse #4 stated she completed the dialysis communication form prior to Resident #65's leaving the facility on her scheduled dialysis days. Nurse #4 stated the information documented on the form prior to dialysis was vital signs, weight, access site condition, and any changes in condition. Nurse #4 stated the dialysis nurse documented on the form their assessment of Resident #65's condition after dialysis was completed. Nurse #4 explained that when the resident returned from dialysis she reviewed the form for information provided by the dialysis nurse.During an interview on 2/17/26 at 3:08 PM, Nurse #3 stated the facility communicated with the dialysis center using a dialysis communication form. She explained that each resident receiving dialysis had a notebook that accompanied them to each dialysis treatment. Prior to the resident leaving the facility, the nurse completed the top portion of the dialysis communication form and placed it in the notebook. The form included pre-dialysis information such as vital signs, dialysis access assessment, and any changes in the resident's condition. After dialysis treatment, the dialysis nurse completed a post-dialysis section of the form and returned it to the resident's notebook for the facility nurse to review. Nurse #3 stated she was unsure how long the completed communication forms remained in the notebook before being removed by medical records staff.During an interview on 2/18/26 at 12:50 PM, the Medical Records Manager stated she was unable to locate any dialysis communication forms for Resident #65. She stated there was no scheduled timeframe for removing completed communication forms from the dialysis notebook and uploading them into the resident's electronic medical record. She stated she believed the communication forms completed since Resident #65's admission remained in the notebook that accompanied the resident to dialysis. She further stated it was possible that upon discharge, the resident's family took the notebook home by mistake. She had attempted to contact the family, but they had not returned her call yet.During an interview on 2/18/26 at 12:55 PM, the Director of Nursing (DON) stated the facility was responsible for completing the dialysis communication form prior to the resident leaving for dialysis and for ensuring the dialysis center completed the post-dialysis section. The DON stated the completed forms should be removed from the notebook and placed in the resident's medical record after review by the facility nurse. The DON was unable to explain why the communication forms were not in Resident #65's medical record.