

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2025
NAME OF PROVIDER OR SUPPLIER Westwood Health and Rehabilitation			STREET ADDRESS, CITY, STATE, ZIP CODE 625 Ashland Street , Archdale, North Carolina, 27263	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint investigation survey was conducted on 10/21/2025. Additional information was obtained on 10/22/2025. Therefore, the exit date was changed to 10/22/2025. Event ID: 1D9C42-H1. The following intakes were investigated: #2646511, #2646746, and #2648115. 4 of the 6 allegations resulted in deficiency.</p> <p>Due to QSO memo 26-01 ALL the posting of this 2567 will be held until the resolution of the federal government shutdown.</p> <p>Per CMS guidance the exit date of this survey was adjusted to 11/14/25 (time of which 2567 being issued to provider after the resolution of the federal government shutdown).</p> <p>Per QSO memo 26-02 the exit date was again amended on 12/5/25 to 11/07/25 as directed in the memo.</p>	F0000		11/21/2025
F0600 SS = D	<p>Free from Abuse and Neglect</p> <p>CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and staff</p>	F0600	<p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 10/4/2025 Resident #2 was assessed immediately following the incident. Physical and skin assessments conducted revealed no injuries or negative findings. Emotional support was provided.</p> <p>On 10/4/2025 Resident #1 was placed under one-on-one supervision, and all staff were instructed to maintain strict separation between the two residents.</p> <p>On 10/4/2025, the Director of Nursing initiated education to all staff on abuse education and resident awareness.</p> <p>On 10/4/2025 Resident #1 was started on Paxil 10 MG for Libido control</p> <p>On 10/4/2025 Responsible parties, law enforcement, APS, and the State Agency and psychiatry were notified promptly by the Executive Director and the Director of Nursing.</p>	11/10/2025

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 reverse for further 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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F0600 SS = D	<p>Continued from page 1 interviews, the facility failed to protect a resident's right to be free from resident to resident sexual abuse when Medication Aide #2 observed Resident #1, a male resident, "fondle" a severely cognitively impaired female resident (Resident #2) when he lifted both of Resident #2's breasts out of the neckline of her V-neck shirt and caressed them with both hands and when Medication Aide #1 observed Resident #1 holding the hand of Resident #2 and rubbing her hand over his pants in his crotch area. Resident #2 did not have the cognitive capacity to consent to this intimate sexual contact. This deficient practice affected 1 of 3 residents reviewed for resident-to-resident abuse (Resident #2).</p> <p>The findings included:</p> <p>A. Resident #1 was admitted to the facility on 12/24/2024 with diagnoses which included unspecified dementia, diabetes mellitus, coronary artery disease, cognitive communication deficit and a history of a cerebral infarction (a condition where blood flow to the brain is interrupted leading to brain tissue damage) with residual right side hemiparesis (weakness on one side of the body).</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 7/21/2025 indicated Resident #1 was moderately cognitively impaired. Resident #1 propelled himself independently in his wheelchair.</p> <p>A review of Resident #1's care plan dated 7/31/2025 indicated the resident had no care plan related to sexually inappropriate behaviors as of 10/4/2025.</p> <p>Resident #2 was admitted to the facility on 11/1/2023 with diagnoses which included Alzheimer's dementia, and adult failure to thrive.</p> <p>A quarterly MDS assessment dated 7/22/2025 indicated Resident #2 was severely cognitively impaired. Resident #2 was severely impaired in the area of daily decision making, she could feed herself with set up/supervision but otherwise required total assistance with all Activities of Daily Living (ADL). Resident #2 was dependent on staff for mobility and transfers to the geriatric recliner.</p> <p>A late entry nursing progress note dated 10/6/2025 at 1:17 AM created by the Weekend Nursing Supervisor #1 indicated on 10/4/2025 she had been told by Medication Aide #2 that Resident #1 had pulled Resident #2's breasts out of her V-neck shirt and was touching them. Staff had separated the residents. Resident #2 was</p>	F0600	<p>Continued from page 1</p> <p>On 10/18/2025 Resident #2 was assessed by the Weekend RN Supervisor for injuries and emotional distress; none were noted.</p> <p>On 10/18/2025, the RN Supervisor had Resident #1 placed on one-to-one supervision. On 10/18/2025, Physician was notified by RN Supervisor and medication administration time was changed to 4pm to increase likelihood of resident accepting medication to continue to address compulsive sexual behaviors. On 10/18/2025, Resident #1 will remain on one-to-one supervision until psychiatry determines risk has decreased, and alternate interventions can be put in place.</p> <p>On 10/18/2025 Responsible parties, law enforcement, APS, and the State Agency and psychiatry were notified promptly by the Executive Director and the Director of Nursing.</p> <p>On 10/21/25 an employee assigned to one-to-one left her assignment without proper coverage.</p> <p>On 10/21/2025, the Director of Nursing re-assigned one-to-one coverage with education on responsibilities. The Staff involved in the immediate situation related to one-to-one coverage were re-educated by nursing leadership on abuse, one to one supervision and notifying supervisor before leaving one-on-one assignment.</p> <p>On 10/27/2025, Resident #1's care plan was revised by MDS Nurse to include interventions for behavioral triggers, supervision needs, and other appropriate interventions.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>On 10/18/2025 the Director of Nursing and Unit Manager and designees completed skin checks on Residents with BIMS <13 to determine risk of exposure to resident-to-resident sexual abuse. No additional findings were noted.</p> <p>On 10/18/2025 the Director of Nursing and Unit Manager</p>	

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F0600 SS = D	<p>Continued from page 2 laughing and Resident #1 was stating "What did I do?". Emotional support was provided to Resident #2. The Administrator, Director of Nursing (DON), Medical Director, Residents' Responsible Parties, Mental Health Provider, Weekend Triage Nurse Practitioner, local law enforcement, and Adult Protective Services (APS) were notified. Resident #1 was started on Prozac, 10 milligrams (mg) capsule by mouth at bedtime for 7 days then increase Prozac to 20 mg by mouth at bedtime. (Prozac is a prescription drug used to treat a variety of mental health conditions. It works by increasing the levels of serotonin, a neurotransmitter that helps regulate mood, emotion and sleep. The side effect of decreased sexual drive is helpful in managing compulsive sexual behavior). A complete blood count (CBC) was ordered for Resident #1 with no abnormal findings. Resident #1 remained on one to one supervision until 11:00 PM on 10/4/2025 then every 15 minute checks were started.</p> <p>A review of the 24-hour Initial Report dated 10/4/2025 at 3:00 PM indicated that staff had notified the Administrator that a male resident (Resident #1) had been observed fondling a female resident (Resident #2). The staff immediately separated the residents. Both residents were assessed and no injuries noted. Resident #1 was placed on one to one supervision. The provider and responsible parties were notified. Local law enforcement was contacted on 10/4/2025 at 4:10 PM. The State Agency was notified on 10/4/2025 at 3:05 PM. The initial report was signed by the Administrator.</p> <p>A review of a local Law Enforcement Incident Report dated 10/4/2025 at 4:41 PM revealed the officer responded to a call in reference to assault with sexual motive between residents. No charges were filed or further action taken.</p> <p>A review of a Nurse Practitioner (NP) note dated 10/6/2025 at 6:19 PM indicated Resident #1 was seen due to inappropriate touching of another resident over the weekend. Psychiatry services were contacted and Prozac was started on 10/4/2025. Resident #1 frequently refused medication and had ongoing behaviors. Recommendations were to increase supervision, redirect inappropriate behavior, continue medications as ordered and encourage compliance and maintain regular psychiatry/psychology follow-up.</p> <p>A review of the 5 Day Investigation summary dated 10/10/2025 indicated staff reported on 10/4/2025 at 2:40 PM that Resident #1 was in his wheelchair and approached Resident #2 seated in a geriatric recliner at the nurses' station. Without warning Resident #1</p>	F0600	<p>Continued from page 2 and designees completed interviews with Residents with BIMS >13 to determine risk of exposure to resident-to-resident sexual abuse. No additional findings were noted.</p> <p>On 10/21/2025 the Director of Nursing and Unit Manager and designees completed a review of the last 30 days – 24-hour report in the EMR to review for any unaddressed behavioral concerns, noted resident to resident interactions that would require additional supervision or interventions. No additional findings were noted.</p> <p>Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 10/18/2025 and 10/21/2025, the Executive Director, Director of Nursing, Unit Manager, and designees began immediate re-education of all staff to include contract staff on abuse prevention, mandatory reporting, and intervention strategies.</p> <p>Training emphasized recognition of sexually inappropriate behaviors, immediate separation of residents, and intervention requirements.</p> <p>This training will also be provided by any newly hired staff to include contract staff during the orientation process by ED/DON or facility designee.</p> <p>On10/21/25 the Director of Nursing implemented a one-to-one coverage process to ensure that relief is identified prior to staff responsible stepping away from assignment. On 10/21/2025 Education on the one-to-one coverage process was provided to nursing staff by Nursing Leadership to ensure understanding of roles and responsibilities.</p> <p>This training will also be provided by any newly hired staff to include contract staff during the orientation process by ED/DON or facility designee.</p> <p>Beginning 10/21/25, Director of Nursing and Unit Managers/facility designee will complete audits daily for 4 weeks, then 5 times a week for 4 weeks, then 3 times per week for 4 weeks on alternating shifts to ensure that one-to-one supervision is provided as required.</p> <p>Each audit will be completed in person on the unit where the one-to-one is assigned.</p>	

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F0600 SS = D	<p>Continued from page 3</p> <p>lifted Resident #2's breasts out of her shirt and began fondling them. Staff immediately separated the residents. During the separation, Resident #1 attempted to hit and bite staff. Both residents were assessed and no injuries noted. Resident #1 was placed on one to one supervision. Local law enforcement arrived at approximately 4:40 PM. No further legal action was anticipated. APS was notified via 911 at 5:11 PM and the APS case worker returned the call at 6:11 PM. No further follow-up was required by APS. Due to the cognitive limitations of both residents, neither was able to provide a reliable account of the incident. Staff interviews were conducted. No further disruptive or inappropriate behavior was noted. The allegation was not substantiated by the facility.</p> <p>On 10/21/2025 at 2:10 PM a telephone interview with Nurse #1 revealed she did not witness Resident #1 touching Resident #2's breasts on 10/4/2025. By the time Nurse #1 had walked up the hallway, Medication Aide #2 and Nurse #2 had separated the residents. The Weekend Nursing Supervisor #1 had started notifying the Administrator, DON and making the necessary reports. Resident #1 was placed on one to one supervision. Nurse #1 was not sure how long Resident #1 had one to one supervision. Nurse #1 stated she had never seen Resident #1 touch anyone inappropriately though he did make inappropriate sexual comments to staff.</p> <p>On 10/21/2025 at 3:20 PM a telephone interview with Nurse #2 indicated she was walking up the hallway on 10/4/2025 and a Nurse Aide (NA) told her what had occurred between Resident #1 and Resident #2. Medication Aide #2 had separated the residents and Nurse #2 started to take Resident #1 back to his room. Nurse #2 stated Resident #1 planted his feet firmly on the floor and attempted to turn his wheelchair around to go back to Resident #2. When Nurse #2 stated they were returning to Resident #1's room, Resident #1 grabbed Nurse #2's arm and tried to pull it to his mouth to bite her. Nurse #2 stated she told Resident #1, "No, you're not going to bite me, that's not what we're doing. We are going back to your room". Nurse #2 stated Resident #2 responded with a few curse words but otherwise complied and returned to his room without further incident. Nurse #2 stated Resident #1 had made sexual comments to staff in the past but she had never heard that he had touched anyone inappropriately until 10/4/2025.</p> <p>On 10/21/2025 at 4:51 PM an interview with Medication Aide #2 revealed that she had walked around the nurses' station on 10/4/2025 and saw Resident #1 in his wheelchair sitting in front of Resident #2 who was</p>	F0600	<p>Continued from page 3</p> <p>The auditing nurse leader will visually confirm the presence of the staff member assigned to the one-to-one and ensure the resident remains in direct line-of-sight, within arm's reach, or per the individualized supervision plan.</p> <p>Beginning 10/21/25, the Executive Director and Social Worker will interview 3 residents with a BIMS >13 per week for 12 weeks to ensure freedom from abuse.</p> <p>Beginning 10/21/2025, the Director of Nursing and Unit managers will complete skin assessments on 3 residents with a BIMS <13 per week for 12 weeks to ensure freedom from abuse.</p> <p>Any concerns identified as a result of the monitoring will have immediate re-education and corrective action as deemed necessary.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>On 10/21/2025, the Executive Director held an ADHOC QAPI meeting to review the root cause, action steps, and monitoring expectations to prevent recurrence.</p> <p>Beginning 10/21/2025, the results of the audits will be provided by the Executive Director monthly for 3 months to the Quality Assurance and Performance Improvement (QAPI) committee.</p> <p>The Quality Assurance and Performance Improvement (QAPI) committee will be responsible for monitoring and making recommendations to amend the plans necessary to ensure sustained compliance.</p> <p>All corrective actions will be fully implemented by the Executive Director by 11/10/2025.</p>	

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F0600 SS = D	<p>Continued from page 4 seated in a geriatric recliner. Resident #1 leaned forward and lifted both of Resident #2's breasts out the top of Resident #2's shirt and began fondling her bare breasts with both hands. Resident #2 was not wearing a bra. Medication Aide #2 immediately told Resident #1 to stop and pulled his wheelchair away from Resident #2. Resident #1 stated "What did I do?". Medication Aide #2 stated Resident #2 did not seem to have any change in her behavior or baseline after the incident. Resident #2 was taken to the dining room for dinner. Nurse #2 had started to push Resident #1 back to his room and he tried to turn around to go back to Resident #2 and attempted to bite Nurse #2.</p> <p>On 10/21/2025 at 5:03 PM a telephone interview with the Weekend Nursing Supervisor #1 indicated she had been working in her office on 10/4/2025 when she was notified by an NA that Resident #1 had fondled Resident #2's breasts. Upon her arrival at the nurses' station, staff had already separated Resident #1 and Resident #2. One to one supervision was started for Resident #1. The Weekend Nursing Supervisor notified the Administrator, DON, local law enforcement, the Medical Director, the Mental Health Provider Weekend Triage Nurse Practitioner and APS. Resident #1 was started on Prozac. No injuries were noted on either Resident #1 or Resident #2. Emotional support was provided to both residents. Resident #2 had no change in her baseline behavior and did not display any distress after the incident.</p> <p>On 10/22/2025 at 10:25 AM a telephone interview with NA #1 indicated she had been charting at the nurses' station and had observed Resident #1 moving about in his wheelchair which was his normal behavior. NA #1 stated all was quiet as she was working until she heard Medication Aide #2 say "Stop that, you can't do that." When she looked over the desk, she saw Resident #1 fondling Resident #2's exposed breasts. The residents were immediately separated by Medication Aide #2, NA #1 and Nurse #2 who had also arrived at the nurses' station. Resident #1 was placed on one to one supervision. On 10/5/2025, NA #1 was Resident #1's assigned NA for the 7:00 AM to 3:00 PM shift. When she arrived on 10/5/2025 at 7:00 AM to begin her shift, NA #1 was told staff was conducting every 15 minute checks for Resident #1 and he no longer had a one to one sitter.</p> <p>B. A review of Resident #1's revised care plan dated 10/6/2025 had a focus area regarding Resident #1 having the potential for sexually inappropriate behaviors related to cognitive loss. The goal was Resident #1 would not harm himself or others through the next</p>	F0600		

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F0600 SS = D	<p>Continued from page 5 review period. Interventions included assess and anticipate the resident's needs, monitor/document/report any signs or symptoms of resident posing a danger to self or others and if resident becomes agitated: intervene before agitation escalate; guide away from source of distress; engage calmly in conversation; and if response is aggressive, staff to walk calmly away and reapproach later.</p> <p>A nursing note dated 10/18/2025 at 9:00 PM indicated Resident #1 was observed taking Resident #2's hand and placing it on his private area and rubbing Resident #2's hand back and forth over his pants. The residents were separated immediately and the Administrator was notified.</p> <p>A nursing note dated 10/18/2025 at 7:00 PM created by the Weekend Nursing Supervisor #1 indicated the Mental Health Provider Triage Physician had been contacted regarding Resident #1's inappropriate sexual behavior. A new order was received to change the Prozac 20 mg daily from capsules to tablets and administer with food as Resident #1 had refused the Prozac on occasion.</p> <p>A review of the 24-hour Initial Report dated 10/18/2025 indicated at 4:30 PM Medication Aide #1 had observed that Resident #1 had rolled his wheelchair up to Resident #2 who was seated in a geriatric recliner. Resident #1 took Resident #2's hand and placed her hand on his genital area and rubbed her hand back and forth over his pants. The staff immediately separated the residents. Both residents were assessed for injuries and any signs of distress with none noted. Resident #1 was placed on one to one supervision. The Administrator, Provider, and the residents' responsible parties were notified. Local law enforcement was called. A facility investigation was initiated.</p> <p>A review of a local Law Enforcement report dated 10/18/2025 at 5:57 PM indicated the officer responded to a call regarding sexual assault between Resident #1 and Resident #2. Resident #1 had taken Resident #2's hand, placed her hand on his private area and rubbed her hand back and forth. The report indicated both residents had dementia, could not recall the incident and APS had been notified. No charges were filed.</p> <p>A nursing note dated 10/19/2025 at 3:25 PM created by Nurse #1 indicated that Resident #1 continued on one to one supervision and no inappropriate behavior had been observed during the shift.</p> <p>On 10/21/2025 at 11:25 AM an interview with Medication Aide #1 revealed she had been walking out of another</p>	F0600		

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F0600 SS = D	<p>Continued from page 6 resident's room when she observed that Resident #1 had rolled his wheelchair up at an angle beside Resident #2 who was in her geriatric recliner at the nurses' station. Resident #1 had taken Resident #2's hand and was rubbing it over his pants in his crotch area. Medication Aide #1 could not recall which hand Resident #1 was using or which of Resident #2's hands he was holding. Medication Aide #1 immediately called the nurse and they separated the residents. Medication Aide #1 took Resident #1 back to his room. Medication Aide #1 stated Resident #1 did not say anything and was cooperative with her. Resident #1 was placed on one to one supervision. Medication Aide #1 stated the nurse notified the Administrator.</p> <p>On 10/21/2025 at 2:10 PM a telephone interview with Nurse #1 indicated she was working on the medication cart on 10/18/2025 and did not witness Resident #1 touching Resident #2. Nurse #1 heard about the incident from other staff and was aware a one to one sitter had been started.</p> <p>On 10/21/2025 at 3:20 pm a telephone interview with Nurse #2 revealed she did not witness Resident #1 touching Resident #2 on 10/18/2025.</p> <p>On 10/21/2025 at 5:03 PM a telephone interview with the Weekend Nursing Supervisor #1 indicated that Medication Aide #1 had alerted her that Resident #1 was observed taking Resident #2's hand, placing Resident #2's hand on his crotch and rubbing Resident #2's hand back and forth over his pants. The residents were immediately separated and assessed for any injury with none noted. Resident #1 was placed on one to one supervision. The Weekend Supervisor #1 notified the Administrator, DON, Medical Director, Mental Health Provider Triage, local law enforcement, APS and the residents' responsible parties. The Weekend Nursing Supervisor #1 received an order from the Mental Health Provider Triage physician to change the Prozac 20 mg capsule to a 20 mg tablet as the tablet could be crushed and added to food since Resident #1 had been refusing medication.</p> <p>On 10/21/2025 at 11:00 AM an interview was attempted with Resident #1. Resident #1 was alert but unable to provide information and appeared to be confused. A one to one sitter was observed stationed at the doorway to his room.</p> <p>On 10/21/2025 at 12:45 PM a telephone voice mail was left for the Nurse Practitioner (NP) with no return call. Subsequent attempts to reach the NP were unsuccessful.</p>	F0600		

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F0600 SS = D	<p>Continued from page 7</p> <p>On 10/21/2025 at 1:29 PM a telephone interview with the Medical Director indicated she had been notified of Resident #1's sexually inappropriate behavior on both 10/4/2025 and 10/18/2025. Resident #1 had cognitive impairment, was known to refuse medication and had behaviors with staff but the Medical Director had never known Resident #1 to touch anyone inappropriately until 10/4/2025. Resident #1 had been started on Prozac and psychiatry was involved. The Medical Director stated Resident #1 had refused medication at times. Resident #1 was currently under one to one supervision and staff was keeping Resident #1 and Resident #2 separated.</p> <p>On 10/21/2025 at 1:57 PM, Resident #1 was observed sitting in his wheelchair at the nurses' station without a one to one sitter.</p> <p>On 10/21/2025 at 2:01 PM a follow-up interview with Medication Aide #1 indicated Resident #1's one to one sitter had been pulled to the floor to provide care for other residents and staff had been told to keep an eye on Resident #1.</p> <p>On 10/21/2025 at 2:36 PM a telephone interview with the Psychiatric Mental Health Nurse Practitioner (PMHNP) revealed he had seen Resident #1 for three months. The PMHNP stated Resident #1 displayed compulsive and impulsive behavior. Resident #1 was forgetful. The PMHNP had been notified by the weekend triage staff that Resident #1 had acted out in a sexually inappropriate manner on 10/4/2025 and again on 10/18/2025. The PMHNP knew of no prior instances when Resident #1 had touched anyone inappropriately. The PMHNP indicated he had not seen Resident #1 since the incidents but was scheduled to see him in the next few days. The PMHNP stated he knew Resident #1 had been started on Prozac.</p> <p>On 10/21/2025 at 3:05 PM, Resident #1 was observed sitting in his wheelchair at the nurses' station without a one to one sitter.</p> <p>On 10/21/2025 at 4:00 PM an interview was attempted with Resident #2. Resident #2 was alert, sitting up in bed but answered questions in a nonsensical manner and appeared to be confused.</p> <p>On 10/21/2025 at 4:30 PM, Resident #1 was observed in the hallway with a one to one sitter.</p> <p>On 10/21/2025 at 5:08 PM an interview with the DON revealed that she had not been in the facility when Resident #1 had touched Resident #2 in a sexually inappropriate manner on 10/4/2025 and 10/18/2025. The</p>	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2025
NAME OF PROVIDER OR SUPPLIER Westwood Health and Rehabilitation			STREET ADDRESS, CITY, STATE, ZIP CODE 625 Ashland Street , Archdale, North Carolina, 27263	
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F0600 SS = D	<p>Continued from page 8 DON was familiar with the 10/4/2025 incident through review of witness statements and nursing reports. The DON stated she was not sure why Resident #1 seemed to seek out Resident #2. The DON stated Resident #1 had remained on one-to-one supervision until cleared by psychiatry/psychology services. The DON stated Resident #1 had been seen by psychiatry after the 10/4/2025 incident. The DON stated staff was unclear about what a one-to-one supervision status meant, and she was already educating staff that the one-to-one sitter stays with the resident no matter where the resident goes. The DON stated she had been on leave and was just starting her investigation into the incident on 10/18/2025.</p> <p>On 10/21/2025 at 5:34 PM an interview with the Administrator indicated he had been notified immediately of both incidents involving Resident #1 and Resident #2 on 10/4/2025 and 10/18/2025. The Administrator did not know why Resident #1 had targeted Resident #2 twice. Resident #1 had not ever touched anyone inappropriately prior to 10/4/2025. The Administrator was aware that staff had not consistently provided one to one supervision on 10/21/2025 but the one-to-one sitter was back in place while the investigation continued for the incident on 10/18/2025. The Administrator stated Resident #1 had been refusing his medications but now the Prozac was able to be placed in food. The Administrator stated the previous social worker had started a search for a more appropriate setting for Resident #1 and the new Social Worker was to start 10/23/2025. The Administrator stated the staff had done their best intervening with Resident #1 and had stopped his inappropriate behavior towards Resident #2 quickly.</p>	F0600		